DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

March 10, 2023

Juliet Charron
Medicaid Director
State of Idaho, Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720

Dear Ms. Charron:

The Centers for Medicare & Medicaid Services (CMS) approved the Evaluation Design for Idaho's Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Idaho Behavioral Health Transformation" (Project Number 11-W-00339/10), effective through March 31, 2025. We sincerely appreciate the state's commitment to efficiently meeting the requirement for an Evaluation Design, as was stipulated in the approval letter for this amendment dated March 11, 2022, especially under these extraordinary circumstances.

The approved Evaluation Design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(e). CMS will also post the approved Evaluation Design on Medicaid.gov.

Consistent with the approved Evaluation Design, the draft Final Report will be due to CMS 18 months after either the expiration of the demonstration approval period or the end of the latest rating period covered under the state's approved expenditure authority, whichever comes later.

We look forward to our continued partnership with you and your staff on the Idaho Behavioral Health Transformation Demonstration. If you have any questions, please contact your CMS project officer, Mr. Julian Taylor. Mr. Taylor can be reached by email at Julian.Taylor@cms.hhs.gov.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2023.03.10 12:17:40 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Courtenay Savage, State Monitoring Lead, Medicaid and CHIP Operations Group

IDAHO RISK MITIGATION EVALUATION DESIGN

Idaho Department of Health and Welfare, Division of Medicaid

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Description and Purpose of Demonstration

The Centers for Medicare & Medicaid Services (CMS) developed a new section 1115(a)(2) demonstration opportunity available to states under title XIX (Medicaid) of the Social Security Act, and pursuant to the demonstration opportunity outlined in State Medicaid Director Letter (SMDL) #20-002.1. The new demonstration opportunity would test whether, in the context of the current COVID-19 public health emergency (PHE), an exemption from the regulatory prohibition in 42 CFR § 438.6(b)(1) promotes the objectives of Medicaid. Specifically, this exemption, using section 1115(a)(2) expenditure authority, would allow states to add or modify risk-sharing mechanism(s) after the start of the applicable rating periods as specified in states' contracts with their Medicaid-managed care plans. Such an expenditure authority is expected to support states with making appropriate, equitable payments during the PHE to help maintain provider capacity and beneficiary access to care during this period. The authority would exempt, as necessary, states from compliance with the current requirements in section438.6(b)(1), until the end of the PHE.

Idaho will participate in this risk mitigation demonstration opportunity. PHE allowances posed barriers to accurately estimating beneficiary utilization, as well as enrollment forecasting, which extended timelines on multiple deliverables. PHE restrictions, and COVID-19 exposure risk-limited resources within the Department, managed care entities, and the provider network statewide. Each of the four managed care entities entered into two risk sharing mechanisms that were not completed prior to the applicable rating periods as specified in the state's contracts and thus making them eligible for this demonstration. The states evaluation will show that allowances to continue making appropriate, equitable payments regardless of delay or modification occurring after the rating period effective dates afforded the state the opportunity to maintain payments to providers already struggling with capacity and beneficiary access statewide. Data analysis of the demonstration will provide valuable information. The state will provide insight to CMS through the following demonstration evaluation on how demonstration allowances kept the state from incurring further compromises to program sustainability, provider capacity, and beneficiary access limitations, as a result of the COVID-19 PHE.

Demonstration Evaluation Questions

1. What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?
    a. General Overview
        a. As shown in Table 1, the state has entered eight risk sharing mechanisms after the start of their applicable rating periods. An overview of the plans, rating period, projected expense and agreement detail can be found in the table with each source hyperlinking to the certification document in question.
    b. Data Sources
        a. Internal Medicaid Management Information System (MMIS) claims data and actuary rate certifications
    c. Analysis to be conducted
        a. Review of the current demonstration certifications risk expenditure, rate development, and risk mitigation analysis conducted.
    d. Anticipated Limitations
        Limitations for this demonstration will include an inability to compare across states or other similar occurrences.

2. To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?
    a. General Overview
        a. Allowance to retroactively implement risk sharing resulted in the state providing actuarily sound rates informed by beneficiary utilization and enrollment data. The state and plans were afforded additional time to agree on a reasonable amount of risk with fewer unknowns of the new population(s), utilization, as well as changes in utilization. Additional time considerably helped the state develop risk sharing that was acceptable by both the plans and the state.
    b. Data Sources
        a. The states actuary reports on capitation development. Data is provided to the actuary by the MMIS team through their system.
    c. Analysis to be conducted
        a. Review of payments made and discussion of payment structure without the demonstration opportunity.
    d. Limitations
        a. The state is limited in that the PHE is ongoing, there are no similar instances for review and comparability to offer guidance.

3. In what ways during the PHE did the demonstration support adding or modifying one or more risk-sharing mechanisms after the start of the rating period?
    a. General Overview
        a. Rating period modification after the contracted start date supported through this demonstration allowed:
            a. Additional COVID claims experience to incorporate into rate modeling post the rating period start date.

b. Retrospectively adjusted rates based on additional emerging utilization during the rating period.
c. Corridor adjustment post rating period start date.
d. As a result of longer than usual rate negotiations with plans, the state was able to certify rates post rating period start date.

b. Data Sources
    a. Internal MMIS claims data and Milliman rate certifications
c. Analysis to be conducted
    a. Review of the current demonstration certifications risk expenditure compared to past and future certifications completed within their contracted timeframes.
d. Anticipated Limitations
    a. Known limitations will exist with the ability to compare PHE and non-PHE beneficiary utilization and enrollment differences.

4. What problems does the state anticipate would have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems?
    a. General Overview
        a. If the state was unable to retrospectively adjust risk-mitigation mechanisms post rating period start date, there would be a high probability plans and/or the state would experience higher gains or losses at the end of the rating period. This could result in compromising program sustainability and potentially access to care challenges.
    b. Data Sources
        a. Internal MMIS claims data and Milliman rate certifications
    c. Analysis to be conducted
        a. Review of the current demonstration certifications, risk expenditure, and breakdown of financial implications if we did not have this opportunity.
    d. Anticipated Limitations
        a. Limitations will exist in that data can only accurately reflect the current certification and timeline of events.

5. What were the principal lessons learned for any future PHEs in implementing the demonstration flexibilities?
    a. General Overview
        a. Over the course of the PHE and experience with setting risk-mitigation mechanisms in rate certifications the state learned several lessons. It is sometimes challenging to predict the unknown and when we experience events such as a pandemic, adding new populations or programs it is imperative to create a risk sharing mechanism that protects both the plans and the state financially while still supporting Medicaid participants access to quality care.
    b. Data Sources
        a. Internal MMIS claims data and Milliman rate certifications
    c. Analysis to be conducted

        a. Analysis of PHE and non-PHE certifications risk expenditure from the perspective of differences in beneficiary enrollment and utilization.
    d. Anticipated Limitations
        a. Limitations for this demonstration will include an inability to compare across states or other similar occurrences.

Demonstration Applicable Certifications

The states plan's covering dual eligible individuals: Idaho Medicaid Plus (IMPlus) and Medicare-Medicaid Coordinated Plan (MMCP) include identical contracts. Each contract entered a certification eligible for this demonstration, these were completed May 2020 and June 2021. The certification documentation for each plan has been linked below in Table 1. For the 2020 certification one outlying concern was membership mix for plans, which required additional time due to the PHE's expansion of eligible individuals. In addition to the retrospective rate adjustment for membership mix, there was also a risk sharing arrangement in the form of a medical loss ratio (MLR) settlement. Retrospectively, The MLR settlement payment will include the component to update the composite rate as well as a settlement for the actual program experience. The calculation attributed and three percent (3%) increase or decrease risk corridor as well as the use of the updated composite rate in the loss ratio settlement are explained further within the certification documentation. Similarly, in 2021, member mix concerns and the effect of PHE eligibility guidance delayed accurate beneficiary allocation.

Behavioral Health services provided through the states Idaho Behavioral Health Plan (IBHP) also has two demonstration eligible certifications both occurring in 2021. In February 2021 the state adjusted annual trends to take into consideration the emerging 2020 experience for the January 2021 through June 2021 rate period. The IBHP saw greater struggles with provider retention and capacity affecting utilization and previously projected calculations during the onset of the PHE. Consistent with prior years, the contract includes an 85% minimum MLR requirement as seen in the certification documentation in Table 1. In April 2021, the state re-certified adding adjustments for the rating period covering July 2021 to June 2022. In this, annual utilization, unit cost trends and impacts of the COVID-19 pandemic including PHE guidance were assessed. Areas that were also addressed included, adjustments for retrospective membership changes, ramp-up of the expansion program, and expected costs attributed to new services covered in state fiscal year (SFY) 2022 which includes the time period of July 1, 2021, through June 30, 2022.

The states dental services through the Idaho Smiles program saw rate certification falling within this demonstration completed in November and December of 2020. Adjustments modified the effective reporting periods from January to December, calendar year reporting to July through June, SFY reporting periods. Capitation rates for new adult groups and the expansion population were addressed. The state implemented expansion in January 2020, projections included stipulations about pent-up demand resulting from new/additional members receiving coverage. This demand inflated projections that were not attainable with PHE restrictions. Adjustments were made to account for the impacts of the COVID19 pandemic and lower utilization than expected.

Lessons Learned

The state will expand upon question five and summarize the positive and negative effects on implementation of this demonstration and its flexibilities and allowances under emergency guidance. The state will touch on access, quality of care and ensuring protection for both the state and its contracted health plans.

Timelines and Major Milestones

The state will submit its draft final report 180-days after the close of the last rating period in this demonstration or 180-days after the end of the PHE, whichever is longer according to CMS guidance. The report will be submitted to the PMDA portal under the current Behavioral Health Transformation (BHT) waiver. As directed by CMS, this demonstration holds no ties to the BHT demonstration efforts.

Table 1

Plan	Rating Period	Projected Expense (M)	Source
IBHP	1/1/2020-6/30/2020	$84.30	202102 – 202106 Behavioral Health Rate Certification (Attachment 1)
IBHP	SFY 2022	$197.60	202107 – 202206 Behavioral Health Rate Certification (Attachment 2)
Idaho Smiles	SFY 2020	$63.5	2021113 SFY Dental Capitation Rate Certification (Attachment 3)
Idaho Smiles	SFY 2021	$70.70	20201218 SFY Dental Capitation Rate Certification (Attachment 4)
IMPlus	CY 2020	$181.10	20200526 MMCP and IMPlus Rate Certification (Attachment 5)
IMPlus	CY 2021	$286.80	20210616 MMCP and IMPlus Rate Certification (Attachment 6)
MMCP	CY 2020	$115.10	20200526 MMCP and IMPlus Rate Certification (Attachment 5)
MMCP	CY 2021	$153.30	20210616 MMCP and IMPlus Rate Certification (Attachment 6)

Attachment 1 - 202101 - 202106 Behavioral Health Rate Certification

January through June 2021 Capitation Rate Development:

Behavioral Health Program Rates for Dual Eligible and Legacy Clients State of Idaho

Prepared for:
Idaho Department of Health and Welfare

Prepared by:
Milliman, Inc.

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February 5, 2021

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Appendices

M1. EXECUTIVE SUMMARY

INTRODUCTION

The Idaho Department of Health and Welfare (IDHW) retained Milliman, Inc. (Milliman) to develop actuarially sound behavioral health capitation rates for the Idaho Behavioral Health Plan (IBHP). This report outlines the data, assumptions, and methodology used in the January through June rate adjustment of the state fiscal year (SFY) 2021 contract for legacy Medicaid only, non-dual members, and the dual Medicare and Medicaid members not enrolled in other managed care programs. The legacy members include all children and adults that are not considered as expansion, and are not dual eligible for Medicare. The SFY 2021 contract covers July 1, 2020 – June 30, 2021. This certification supplements the previous one submitted to CMS dated October 19, 2020 and reflects a January 1, 2021 contract amendment to add additional covered state plan services effective on this date.

Beginning on September 2013, Optum began providing managed care to Medicaid eligible clients through IBHP and has received two capitation rates identified as dual and non-dual. IBHP covers most professional outpatient mental health services not in a facility, including family therapy, psychiatric rehab services, targeted case management, and therapy with patient and family. IBHP is mandatory for all eligible Medicaid clients, except those enrolled in the Medicare-Medicaid Coordinated Plan (MMCP) and the Idaho Medicaid Plus (IMPlus) programs.

Beginning January 2020 Optum also began to include Medicaid expansion members under managed care. A third capitation rate for this population is addressed under a separate certification. This certification addresses the capitation rates for the legacy (traditional Medicaid excluding both expansion and dually eligible members) and members eligible for both Medicare and Medicaid (dually eligible) that were not part of Medicaid expansion.

In developing the legacy and dual capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2020-2021 Medicaid Managed Care Rate Development Guide (CMS Guide), published July 2020:

> The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
>
> The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
>
> The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

CMS Guide Index [Section I.1.B]

We indexed each section of this report to the corresponding section of the “2020-2021 Medicaid Managed Care Rate Development Guide”. For example, the contents within the brackets above refer to Section I, subsection 1 “General Information”, bullet B “Appropriate Documentation”. This notation appears in the table of contents as well as the body of this rate certification.

CAPITATION RATES

Table 1 reflects the monthly capitation rates effective January 1, 2021 through June 30, 2021 for each rate cell within the July 1, 2020 through June 30, 2021 (SFY 2021) contract.

Table 1
Idaho Department of Health and Welfare
Behavioral Health Plan
January 1, 2021 - June 30, 2021 Rates

	Contracted Rate PMPM 1/2021 - 6/2021
Legacy	$42.04
Duals	$59.69

The information contained in this certification shows a build-up in support of the remaining six months of capitation rates. These rates are informed by financial summaries of emerging calendar year 2020 experience for each population, adjusted for new services added January 1, 2021 and expected trends to the rating period, including any impacts from the public health emergency. For presentation purposes in this actuarial certification, we have kept the base period consistent with the base period in our prior actuarial certification and included the impact of using more recent historical data summaries as an implicit part of our annual trend assumption.

APPENDICES

Appendix A details the development of the legacy and dual IBHP rates.

Appendix B shows the historical base period experience for the legacy and dual populations by service category.

M2. MEDICAID MANAGED CARE RATES [SECTION I]

GENERAL INFORMATION [SECTION I.1]

Rate Development Standards [Section I.1.A]

Rating Period [Section I.1.A.i]:

This rate certification is for a 6-month rating period effective January 2021 through June 2021.

Items included in an acceptable rate certification [Section I.1.A.ii]:

a. *A letter from the certifying actuary:*

See Section M6 for the rate certification at the end of this report.

b. *The final and certified capitation rates for all rate cells:*

The final and certified rates eligible for federal financial participation can be found in Table 1.

Appendix A steps through the adjustments to reach the rate for each rate cell.

- Calendar Year (CY) 2019 data collected from Optum and provided by IDHW was summarized by rate cell and limited to covered services and populations.
- The following adjustments are applied to project these claim costs to the January 2021 thru June 2021 rate period:
  - Adjustment for annual trends in consideration of emerging 2020 experience.
  - Adjustment for the impact of the COVID-19 pandemic.
  - Adjustment for retrospective membership changes.
  - Addition for expected costs of new services in SFY 2021.
- A 13.5% non-benefit expense load is applied for the dual population and a 13.4% non-benefit expense load is applied for the legacy population.

Additional information regarding the development of the behavioral health capitation rates is detailed in this report.

c. *Descriptions of the program:*

(i) A summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

(A) The types and numbers of managed care plans included in the rate development:

For this program, the state is currently served by one managed care provider (Optum). Prior to Optum, these services were provided on a fee-for-service basis.

(B) A general description or list of the benefits that are required to be provided by the managed care plan or plans:

Optum is required to provide certain non-facility behavioral health services covered under the state plan. The State Plan for behavioral health services covers a variety of core provider services. Historical experience is summarized by service category and shown in Appendix B. The covered services do not vary by covered population. All covered services are consistent with the State Plan.

In addition to the required state plan services, Optum chooses to provide some services as “value add” or “community reinvestment” services. These services were originally provided by Optum as a way of spending reserve funds leftover from prior years. The one current community reinvestment service is for Community Transition Support (HCPC = H2015). This service is excluded in our claim cost projections.

(C) The areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

Optum has been providing statewide coverage since September 2013.

(ii) Rating period:

The rating period covered by this rate certification is January 2021 through July 2021.

(iii) Covered populations:

Both legacy and dual populations are covered under this program. The legacy population includes all non-dual, non-expansion members, including adults, not eligible for expansion, and children. The dual population excludes those members enrolled in the Medicare-Medicaid Coordinated Plan and the Idaho Medicaid Plus programs.

(iv) Eligibility and enrollment criteria:

Enrollment in IBHP is mandatory for the covered populations.

(v) Special contract provisions:

Not applicable.

(vi) Retroactive Adjustments:

Not applicable.

Differences between covered populations [Section I.1.A.iii]:

Any differences among capitation rates according to covered populations are based on valid rate development standards (such as differences in historical experience) and are not based on the rate of federal financial participation associated with the covered populations.

Cross-subsidization [Section I.1.A.iv]:

Capitation rates were developed such that payments from any rate cell do not cross-subsidize payments from any other rate cell.

Consistency of effective dates [Section I.1.A.v]:

The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, and payment rate requirements) are consistent with the assumptions used to develop the capitation rates. These changes have been summarized in Section M1. Executive Summary, with detail included within the assumption documentation sections.

Considerations for MLR standards [Section I.1.A.vi]:

The capitation rates for each base behavioral health population include a 13.4% and 13.5% non-benefit cost assumption in the capitation rate.

Based on these assumptions, we project managed care entities will achieve MLRs above 85%.

Additionally, Optum is required to provide periodic reports of Medical Loss Ratio (MLR), in a time and manner established by the DWH, and in accordance with CMS' methodology [Id. § 438.8(e)]. Reports must be submitted no later than within 12 months of the end of a year for which the MLR pertains. All third party vendors providing claims adjudications activities are required to provide all underlying data associated with MLR reporting to the vendor within 180 days of the end of the MLR reporting year, or within 30 days of a request by the vendor (whichever comes sooner) to calculate and validate the accuracy of MLR reporting.

Considerations for CMS [Section I.1.A.vii]: *As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:*

a. *all adjustments are reasonable, appropriate, and attainable in the actuary's judgment.*

   All adjustments applied during the capitation rate development have been documented herein and are certified as part of the overall rates as reasonable, appropriate, and attainable by the certifying actuary.

b. *adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.*

   We have not made additional adjustments outside the rate setting process documented herein.

c. *consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell.*

It is our understanding that the final contracted rates paid to the managed care entities for each rate cell are consistent with the capitation rates included in Table 1.

Certification period [Section I.1.A.viii]:

Rates are effective and certified for January 2021 through June 2021, and reflect a mid-year rate adjustment to the SFY2021 contract period.

Procedures for rate certifications for rate and contract amendments [Section I.1.A.ix]:

Not applicable.

Appropriate Documentation [Section I.1.B]

Documentation detail required [Section I.1.B.i]: *States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:*

a. *Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources.*

The base claims encounter data used to develop the capitation rates were from calendar year (CY) 2019 (January 1, 2019 – December 31, 2019), including run-out claims through March 2020. The State of Idaho provided this encounter data from Optum for the covered populations. We were able to identify the same populations from the capitation files (also provided by the IDHW), which identified the populations covered by this contract. We determined that these sources of experience were a credible set of base data for all covered populations. For the January 1, 2021 contract amendment, CY 2020 financial reports from Optum using claims paid through November 2020 were used to further inform the trend assumptions.

b. *Assumptions made:*

Details supporting all assumptions are provided throughout this document. The following adjustments have been applied during rate development:

- PMPM trends from base period to rate period
- Impact of the COVID-19 pandemic
- Retrospective membership changes
- New services
- Non-Benefit expenses

Methodology applied in developing assumptions and adjustments are described throughout this document where assumptions are identified.

Rate Ranges [Section I.1.B.ii]

Rates are based on point estimates and ranges were not used.

Rate certification index [Section I.1.B.iii]

The table of contents of this document serves as the rate certification index.

Differences in FMAP [Section I.1.B.iv]

There are no rate development assumptions or methodologies that differ based on the rate of FMAP.

Managed care program additional documentation requests [Section I.1.B.v]

a. *Comparison to previous certified rates*

The changes in the January 2021 thru June 2021 rates compared to the certified SFY 2020 rates, both gross and net of withhold, as well as the prior SFY2021 rates are shown in the table below. Note while current and prior rates have no withhold component, the SFY2020 rates for the legacy population included a withhold arrangement. The changes relative to the SFY2020 rates are presented both gross and net of withhold, showing the scenarios if full withhold is distributed or no withhold is distributed.

Table 2
Idaho Department of Health and Welfare
Behavioral Health Plan
Change in Rates

	1/2021 - 6/2021	Prior Rate (SFY 20 Gross)	Prior Rate (SFY 20 Net)	Rate Change (Gross)	Rate Change (Net)
Legacy	$42.04	$38.78	$36.84	8.4%	14.1%
Duals	$59.69	$73.17	$73.17	-18.4%	-18.4%

	1/2021 - 6/2021	Prior Rate (7/2020-12/2020)	Rate Change
Legacy	$42.04	$40.74	3.2%
Duals	$59.69	$58.43	2.2%

The legacy rate cell costs have had positive trends lately, and CY 2020 emerging experience indicates this trend is continuing with no slow-downs in utilization due to the COVID-19 pandemic.

For the duals rate cell the claim costs continue to trend downward on both an overall and PMPM basis, with the PMPM costs from SFY 2017 to SFY 2019 decreasing over 20%. This rate cell experienced a large membership drop at the beginning of SFY 2020 (as more dual-eligible members enrolled in the MMCP and Idaho Medicaid Plus programs) and overall duals costs decreased significantly since July 2019 due to the growth in these alternative managed care programs. The CY 2020 emerging experience however stopped this decline and since July 2020 a small increase in utilization due to the COVID-19 pandemic is emerging.

b. *Description of any material changes to the rates or rate development process not addressed elsewhere*

Not applicable.

Known Amendments [Section I.1.B.vi]

This certification is meant to supplement the previous certification submitted to CMS dated October 19. 2020. This certification accounts for the rates effective on January 1, 2021 that correspond to the new services beginning on January 1, 2021 and consider the emerging experience in selecting trends.

Rates from the previous certification submitted to CMS dated October 19, 2020 were paid through December 2020 and then these new rates will be paid starting January 1, 2021 through June 30, 2021.

Data [Section I.2]

Rate Development Standards [Section 1.2.A]

Base data standards [Section I.2.A.i]:

a. *Validated data and audited financial reports*

The IDHW provided validated encounter data for use in rate development, specific to the covered population, which was a starting point for this rate build. We have not audited or verified this data and other information, but we did compare data to financial summaries provided by the IDHW for reasonableness

b. *Appropriate base data period*

We constructed rates using CY 2019 claims and capitation payment data received from the IDHW, which was the most recent complete year of data available at the time of the analysis. More recent information, in the form of financial summaries, were incorporated where we deemed necessary.

c. *Appropriate base data population*

We derived the base data from the same base behavioral health population covered under this certification.

d. *Alternative data sources*

Not applicable.

Appropriate Documentation [Section I.2.B]

Description of data requested [Section I.2.B.i]: *In accordance with 42 CFR §438.7(b)(1), the rate certification must include:*

a. *A description of base data requested and used by the actuary for the rate setting process, including:*

(i) A summary of the base data that was requested by the actuary.

Detailed claims, eligibility, and capitation files through CY 2019 were requested along with financial reports through November 2020. We also requested information related to fee schedule changes and benefit changes.

(ii) A summary of the base data that was provided by the state.

All requested data was provided.

(iii) An explanation of why any base data requested was not provided by the state.

Not applicable.

Description of data used to develop rates [Section I.2.B.ii]: *The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including:*

a. *Description of the data.*

We utilized managed care encounter data and health plan financial data.

We used the CY 2019 encounter data for the base period with runout through March 2020. More recent encounter data had not yet been reviewed at the time of our analysis, though we did receive more recent financial summaries (showing claims incurred in CY 2020 and paid through November 2020) that were considered in our selection of trend assumptions.

We received all data related to the base behavioral health population from the IDHW. Some assumptions were developed using information based on our experiences with other states and Milliman research.

There are no sub-capitated costs in the base experience period.

b. *Data availability and quality:*

(i) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:

(A) completeness of the data.

(B) accuracy of the data.

(C) consistency of the data across data sources.

We have summarized the base period of data by HCPC code based behavioral health groupings and eligibility population. Our analysis excluded any duplicate records, claims for non-covered populations, and claims for non-covered services. From the data, we were able to calculate historical utilization and unit cost values, as well as the resulting PMPM costs. These summaries allow us to evaluate the data for reasonableness and compare to prior years' data and other data sources. We were able to determine the data is complete, accurate, and consistent, and have no concerns about the data. Data was not provided with the ultimate run-out of claims, so an adjustment was made to complete the base data for claims incurred but not paid (divide by 0.998).

(ii) a summary of the actuary's assessment of the data.

As the certifying actuary, I have assessed the quality of available data to be sufficient for the purpose of developing projected capitation rates effective during the contract period for the dual and legacy population.

All data were reviewed at several levels by consultants, actuaries, and data analysts who have experience with Medicaid data. We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent.

(iii) *any other concerns that the actuary has over the availability or quality of the data.*

Not applicable.

c. *Data appropriateness: a description of how the actuary determined what data was appropriate to use for the rating period, including:*

(i) *if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.*

Not applicable. Recent managed care encounter data for the covered populations was used.

(ii) *if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.*

Not applicable.

d. *Reliance on a data book:*

Not applicable.

Description of data adjustments [Section I.2.B.iii]:

a. *Credibility:*

Not applicable.

b. *Completion factors:*

Data was not provided with the ultimate run-out of claims, so an adjustment was made to complete the base data for claims incurred but not paid (divide by 0.998).

c. *Data errors:*

Not applicable.

d. *Program changes:*

Effective January 1, 2020, Optum began covering Partial Hospitalization, Crisis Services, and Recovery Coaching. Since our base data only goes through December 2019, the costs for these new services are not included in the base data. Estimated per member per month costs were added to the projected 2021 costs based on projections provided by Optum. We reviewed these projections for reasonableness by comparing them to emerging experience for these services in the first three months of 2020. We relied on these projections as a best estimate since our understanding is that these benefits were previously being provided by the Department of Behavioral Health (DBH), which provides services to all, regardless of insurance type. As a result, historical utilization for the population to be covered under Optum was not available for the SFY 2021 rate certification. These services added approximately $2.15 PMPM to the legacy rate and $0.69 PMPM to the dual rate.

In addition, effective January 1, 2021, Optum will begin covering the drug portion of Opioid Treatment Program (OTP) services, in addition to the therapy costs that have historically been covered. Cost projections for these services were provided by Optum based on their emerging CY 2020 experience of non-drug OTP services and the expected incremental cost of the drugs. We reviewed these projections for reasonableness and converted these costs into PMPMs. These OTP services add approximately $0.29 PMPM to the legacy rate and $0.28 PMPM to the dual rate over the six month rate period.

e. *Exclusions:*

Not applicable.

PROJECTED BENEFIT COSTS AND TRENDS [SECTION I.3]

Rate Development Standards [Section I.3.A]

Services in final rates [Section I.3.A.i]:

Final capitation rates are based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

Variations in assumptions [Section I.3.A.ii]:

Variations in the assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

Development of benefit cost trends [Section I.3.A.iii]:

See section I.3.B.iii.

In-lieu-of services [Section I.3.A.iv]:

Not applicable.

Costs associated with IMDs [Section I.3.A.v]:

Not applicable.

Appropriate Documentation [Section I.3.B]

Projected benefit costs [Section I.3.B.i]:

Appendix A shows the development of the projected benefit costs.

Development of projected benefit costs [Section I.3.B.ii]:

a. *Description of the data, assumptions and methodologies used to develop the projected benefit costs.*

   We relied on data supplied by the IDHW, conversations with the IDHW, internal Milliman research and publicly available data sources to develop assumptions to adjust the base period data and produce projected benefit cost estimates.

   See Section 1.3.B.iii for additional information regarding the data, assumptions and methodologies used to develop the trends.

b. Material changes to the data, assumptions and methodologies since the last rate certification.

   Not applicable.

c. The amount of overpayments to providers and a description of how the state accounted for this in rate development.

   Not applicable.

Trends [Section I.3.B.iii]:

a. *This section must include:*

(i) Data and assumptions used to develop trends:

(A) Descriptions of data and assumptions.

Trend adjustments were applied to the base data on a PMPM basis to project to the effective period. The table below presents applied annual trends.

Table 3
Idaho Department of Health and Welfare
Behavioral Health Plan
Annual Trend - All Services

	PMPM Trend
Legacy	3.9%
Duals	3.1%

We selected these trend assumptions based upon our review of a number of different sources. First, Optum provided data summaries of their total PMPM costs through November 2020 based on incurred claims and expected incurred but not reported claims. These reports were reviewed for reasonableness and used to set trends from the base period (CY 2019) to mid-2020. A breakdown of utilization versus unit cost was unavailable for this period. Next, an additional trend was applied to project costs to the mid-point of the January 2021 through June 2021 rate period. This trend was based on our review of historical Idaho Medicaid behavioral health data and various Milliman manuals (Ages 65 and Over Health Cost Guidelines, Commercial Managed Care Rating Model). There are not expected to be any fee schedule changes occurring between the base period and projection period, so no unit cost changes are expected. However, based on discussions with Optum, we have been expecting to see a shift towards utilization of services with a lower average cost/unit. The financial summaries provided by Optum did not include utilization counts to evaluate the change in cost/unit due to service mix. For this reason, the PMPM trend is applied as an overall PMPM adjustment in Appendix A.

Note an additional one-time 2.5% load was applied to reflect additional increases in utilization expected due to the COVID-19 pandemic. We arrived at this assumption through discussions between Milliman, Optum, and IDHW.

(B) Reliance on experience

While we reviewed historical program experience, we relied on a number of sources to develop our trend assumption, as described above.

(ii) Methodologies used to develop trends:

Historical trends were relied upon partially in setting trends for this program. However, due to some newly covered services, historical trends cannot be relied upon completely. Particularly, there are a number of newly covered services that had minimal utilization in the base period but are expected to experience additional service adoption growth through SFY 2021. We relied on PMPM data summaries of experience in 2020 provided by Optum to incorporate the new service growth into our trends. We reviewed the data summaries provided by Optum for reasonableness by comparing them to expected costs and historical trends and found them to be in line with expectations. We also applied additional trends to project data through the mid-point of the projection period. For this, we placed reliance on the Milliman Managed Care Rating Model for the Commercial Population.

While the trend methodology is consistent for both the dual and legacy populations, the overall trend assumptions differ for each population based on the difference in emerging experience in CY 2020 and expected developments into 2021.

(iii) Comparisons to historical trends:

For most of the program experience, historical PMPM trends have been negative. More recent trends have been positive, specifically for the legacy population, in part due to the additional services covered and increased fee schedules from SFY 2017 and SFY 2018.

Table 4
Idaho Department of Health and Welfare
Behavioral Health Plan
Historical Trends

	Dual			Legacy		
Period	Util/1000	Unit Cost	PMPM	Util/1000	Unit Cost	PMPM
SFY17	4,813.51	$13.43	$64.63	1,123.34	$21.41	$24.05
SFY18	4,126.49	$14.47	$59.72	1,113.76	$22.65	$25.23
SFY19	3,433.82	$15.51	$53.27	1,281.76	$22.18	$28.43
SFY 18/17	-14.3%	7.8%	-7.6%	-0.9%	5.8%	4.9%
SFY 19/18	-16.8%	7.2%	-10.8%	15.1%	-2.1%	12.7%

(iv) Outlier and negative trends:

No negative or outlier trends were applied.

b. *Components of trend:*

As described above, trend is applied as a PMPM trend and we have not identified any specific components. We do note that there are no fee schedule changes planned over the contract period, most of the trend is utilization.

c. *Variations in trend:*

Trend assumptions vary by population only in that the emerging experience in CY 2020 is different between the dual and legacy populations.

d. *Other material adjustments to trend:*

In addition to our standard trend analysis, we also considered potential impact of the emerging situation regarding the COVID-19 pandemic. There is uncertainty regarding the impact of COVID-19 on future claims costs, including whether the pandemic will increase or decrease costs in SFY 2021. For behavioral health services included under this contract, we have not observed any notable amount of deferred or avoided services through CY 2020, with costs instead appearing to trend at an even higher rate in the emerging experience. Additionally, literature such as the Kaiser Family Foundation Issue Brief "The Implications of COVID-19 for Mental Health and Substance Use"[1] note the pandemic is likely to have both long-and short-term adverse implications for mental health and substance use. Therefore, in addition to the trend factors above, a 1.025 one-time adjustment was applied to projection period utilization to account for expected utilization increases in 2021 due to the COVID-19 pandemic. This adjustment was applied to both the dual and legacy populations.

e. *Other non-material adjustments to trend:*

Not applicable.

Adjustments due to MHPAEA [Section I.3.B.iv]:

Not applicable.

In-lieu-of services [Section I.3.B.v]:

Not applicable.

Retrospective eligibility periods [Section I.3.B.vi]:

a. *the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period.*

Optum is required to pay claims incurred during the retroactive eligibility period, even though they do not receive a capitation payment for that member.

[1] Source published August 21, 2020: https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

b. *how the claims information are included in the base data.*

The base data is limited to only include claims that correspond to members with a valid capitation record in that month. Since retrospective eligibility periods are not paid by a capitation the base data does not include the claims information associated with retrospective eligibility.

c. *how the enrollment or exposure information is included in the base data.*

The base data is limited to only include enrollment for members with a valid capitation record in that month. Since retrospective eligibility periods are not paid by a capitation the base data does not include the exposure information associated with retrospective eligibility.

d. *how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments*

In prior rate settings, these claim payments were assumed to be de minimis and covered within the projected underwriting gain. For the CY 2021 rate setting, a 1.008 one-time adjustment factor was applied for retroactive membership changes. There are certain members without a capitation record that Optum paid claims for. Because no capitation record exists for these members, these costs were not included in our base period data. In our base period, these excluded costs represented 0.8% of the total paid dollars. The 1.008 adjustment adds back in these costs, spread across both populations, as similar levels of these claims are expected in SFY 2021.

Changes to covered benefits or services [Section I.3.B.vii]:

a. *More or fewer state plan benefits covered by Medicaid managed care.*

See Section I.2.B.iii.(d).

b. *Any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d).*

See Section I.3.B.ii.(c).

c. *Requirements related to payments from health plans to any providers or class of providers.*

See Section I. 4.D.

d. *Requirements or conditions of any applicable waivers.*

We are not aware of any new requirements that would be included as covered benefits under the managed care entity.

e. *Requirements of conditions of any litigation to which the state is subjected.*

We are not aware of any requirements or conditions of any litigation to which the state is subjected.

Impact of changes to covered benefits or services [Section I.3.B.viii]:

SEE SECTION I.2.B.(III).(D).

SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT [SECTION I.4]

Incentive Arrangements [Section I.4.A]

Rate Development Standards [Section I.4.A.i]

See section 1.4.A.ii.

Appropriate Documentation [Section I.4.A.ii]

Representing a change from prior years, contract provisions no longer include an incentive arrangement nor a withhold arrangement. As a result, the final amount paid to Optum will end up being 100% of the capitation rate for the legacy population, and 100% of the capitation rate for the dual population.

Withhold Arrangements [Section I.4.B]

Rate Development Standards [Section I.4.B.i]

See section 1.4.B.ii.

Appropriate Documentation [Section I.4.B.ii]

In a change from the prior certifications, there is no longer an initial 5% withhold from the capitation rate for the legacy population for the SFY2021 contract period. Both the legacy and dual populations have no portion of the capitation rate withheld for SFY 2021.

Risk-Sharing Mechanisms [Section I.4.C]

Rate Development Standards [Section I.4.C.i]

See section 1.4.C.ii.

Appropriate Documentation [Section I.4.C.ii]

Consistent with prior years, the contract includes an 85% minimum medical loss ratio (MLR) requirement. The MLR limits the amount of profit that Optum is able to achieve on the total combined dual and legacy population (not including expansion). If Optum has a MLR less than 85%, the unspent claim dollars must be placed in a reserve account (or remitted to the state). This money must be reinvested in the program, in the form of community reinvestment (community health initiative) or remitted to the state.

Per the contract, the calculation of the MLR is defined as the sum of the Contractor's incurred claims; and expenditures on activities that improve health care quality; and fraud prevention activities (limited to zero point five percent (0.5%) of the Contractor's premium revenues); divided by premium revenue as defined in 42 CFR § 438.8(a) through (i).

Delivery System and Provider Payment Initiatives [Section I.4.D]

Rate Development Standards [Section I.4.D.i]

See section 1.4.D.ii.

Appropriate Documentation [Section I.4.D.ii]

We understand Optum continues to implement their “Achievements in Clinical Excellence” (ACE) program in Idaho. This program identifies clinicians and groups delivering outstanding care based on regionally adjusted nationwide metrics, with identified providers receiving an extra 3% over the fee schedule. We understand this fee schedule increase is on top of any fee schedule increases otherwise given. This program has been in effect for a number of years already and no major changes are expected in SFY 2021 that would impact capitation rates. There are no other additional directed payments in the program that are not addressed in this certification and there are not any requirements regarding the reimbursement rates that Optum must pay to any providers.

Pass-Through Payments [Section I.4.E]

Rate Development Standards [Section I.4.E.i]

Not applicable.

Appropriate Documentation [Section I.4.E.ii]

Not applicable.

PROJECTED NON-BENEFIT COSTS [SECTION I.5]

Rate Development Standards [Section I.5.A]

See Section I.5.B.

Appropriate Documentation [Section I.5.B]

Description of non-benefit cost projection [Section I.5.B.i]:

a. Description of data, assumptions and methodologies

Rates include a non-benefit expense load of 13.4% and 13.5% of premium for the legacy and non-dual populations, respectively. This load accounts for the administrative costs associated with a managed care program and margin.

The administrative portion was set equal to Optum’s historical SFY 2018 and 2019 reported costs. We understand Optum expects administrative costs in SFY 2021 to be similar to this historical experience.

The administrative allowance is inclusive of projected quality improvement related costs, as well as taxes and fees. The load based on the following non-benefit cost assumptions:

- Administration expense allocation: 12.4% and 12.5% of premium
- Underwriting gain: 1.0% of premium.

b. Material changes to the data, assumptions and methodologies since the last rate certification.

In prior rate certifications before SFY 2021, the non-benefit expense load was set at 15.0% of premium, which is the maximum amount allowed by the contract. However, prior certifications also considered the withhold provision in place for the legacy population. Optum's rates had the maximum non-benefit expense load, but a portion of the legacy population's rate would be withheld every month. With the removal of the withhold arrangement, the administrative costs have simply been projected based on historical administrative costs.

c. Other material adjustments

Not applicable.

Categories of non-benefit costs [Section I.5.B.ii]:

See Section I.5.B.i.

Historical non-benefit costs [Section I.5.B.iii]:

Historical non-benefit costs for SFY 2017 through SFY 2019 were provided by Optum and divided into administrative costs, QI/HIT costs, and taxes and fees. These amounts are shown in the table below as a percent of revenue, net of withhold.

Table 5
Idaho Department of Health and Welfare
Behavioral Health Plan
Historical Non-Benefit Costs

	Administrative	QI/HIT	Taxes and Fees	Total
SFY 2017	5.7%	2.2%	3.4%	11.3%
SFY 2018	7.2%	2.5%	2.7%	12.3%
SFY 2019	7.5%	2.4%	2.7%	12.7%

Health Insurance Providers Fee [Section I.5.B.iv]:

The administrative allowance does not include for the costs of the Health Insurance Providers Fee (HIF). Our understanding is that Optum is not required to pay this fee, and this fee is no longer in place for 2021.

RISK ADJUSTMENT AND ACUITY ADJUSTMENTS [SECTION I.6]

Rate Development Standards [Section I.6.A]

See Section I.6.B.

Appropriate Documentation [Section I.6.B]

Description of all prospective risk adjustment methodologies [Section I.6.B.i]:

Not applicable.

Description of all retrospective risk adjustment methodologies [Section I.6.B.ii]:

Not applicable.

Additional rate certification and supporting documentation requirements [Section I.6.B.iii]:

Not applicable.

Description of acuity adjustments [Section I.6.B.iv]:

No acuity adjustments were made. Because the program is statewide and mandatory for all eligible members, there are no adjustments made for favorable or adverse selection. Also, the base data reflects experience for a managed care environment. The services became capitated in September 2013, and we do not anticipate any additional managed care savings beyond what was realized through the base period. Our review of historical data shows that most savings were realized in the first couple years of the program. Therefore, no additional adjustment has been made for managed care savings

M3. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS [SECTION II]

Not applicable. These services are not covered under this program.

M4. NEW ADULT GROUP CAPITATION RATES [SECTION III]

Not applicable. The new expansion population is not included under this certification.

M5. DATA RELIANCE AND CAVEATS

This document and its attached exhibits, appendices and data are intended for use by the IDHW in support of its SFY 2021 dual and legacy behavioral health capitation rates. This report may be shared with CMS for that purpose. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this presentation to other third parties. Similarly, third parties are instructed that they are to place no reliance upon this analysis prepared for the IDHW by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. The terms of Milliman's contract with the IDHW effective July 1, 2019 apply to this analysis and its use. Other parties receiving this report must rely upon their own experts in drawing conclusions about the data underlying the cost model. It is the responsibility of any insurance carrier to establish required revenue levels appropriate for their risk, management, and contractual obligations for the prospective population.

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual Optum experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis.

We have relied on data from numerous sources to compile this report. This report and associated analyses rely extensively on data provided by the IDHW. These data include, among other items, eligibility, capitation payment records, and encounters for both mental health benefits. We have not audited or verified this data, though we have compared some of the data provided to us to financial summaries provided by the IDHW in order to assess the reasonableness of the data. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review of the data to search for data values that are of questionable validity or for relationships which are materially inconsistent. Such a review was beyond the scope of our assignment.

Models used in the preparation of our analysis were applied consistently with their intended use. Where we relied on models developed by others, we have made a reasonable effort to understand the intended purpose, general operation, dependencies, and sensitivities of these models.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

M6. ACTUARIAL CERTIFICATION

I, Benjamin J. Diederich, am a consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Idaho Department of Health and Welfare (IDHW) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for Idaho's managed care behavioral health program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the six month period of January 2021 to June 2021.

To the best of my information, knowledge and belief, for the January 2021 to June 2021 period, the capitation rates offered by the IDHW are actuarially sound and comply with the requirements of 42 CFR § 438.4, the CMS Managed Care Rate Setting Guide and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on ACOs, MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the ACO, MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the IDHW and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

_____

Benjamin J. Diederich, FSA, MAAA
Consulting Actuary

February 5, 2021

_____

Date

Appendix A
Idaho Department of Health and Welfare
Behavioral Health Plan
January 1, 2021 - June 30, 2021 Rate Development

	Idaho Medicaid Population	
	Legacy	**Duals**
Base Year Data Average		
Base Period	CY2019	CY2019
Average Members	238,759	14,953
Paid (1)	$88,101,778	$8,335,519
Units (2)	3,991,915	517,202
Units/1,000	16,719	34,589
Cost/Unit	$22.07	$16.12
PMPM	$30.75	$46.45
Annual Trends		
PMPM Trend	1.039	1.031
One-time Adjustments		
COVID-19 Adjustment	1.025	1.025
Retroactive Membership Adjustment	1.008	1.008
SFY 2021 Claim Projection		
Average Members	232,779	5,550
PMPM	$33.96	$50.67
Additional Benefits PMPM	$2.44	$0.97
Recovery Coaching (starts 1/1/2020)	$0.04	$0.04
Partial Hospitalization (starts 1/1/2020)	$1.46	$0.00
Crisis Services (starts 1/1/2020)	$0.65	$0.65
OTP Bundle (starts 1/1/2021)	$0.29	$0.28
PMPM w/ Additive Benefits	$36.40	$51.63
Non-Benefit Assumptions		
Non-Benefit % of Total PMPM	13.4%	13.5%
Non-Benefit Expenses	$5.64	$8.06
Total Certified Rate	**$42.04**	**$59.69**

(1) Estimated incurred amount, adjusted for completion.
(2) HCPC reported units

Appendix B-1
Idaho Department of Health and Welfare
Behavioral Health Plan
Legacy Historical Data Summaries for Rate Development: January 1, 2019 - December 31, 2019

Average Members: 238,759

	CY19					
	Paid	**Procedures**	**Units**	**PMPM**	**Paid/Proc**	**Paid/Unit**
Community Reintegration	$16	3	1	$0.00	$5.34	$16.00
E/M - Therapy - Addl 30 Min	$168,539	5,967	5,021	$0.06	$28.24	$33.57
Eval - Nontherapist	$2,176,891	25,279	105,698	$0.76	$86.11	$20.60
Fam therapy w/o patient	$2,180,567	30,556	27,572	$0.76	$71.36	$79.09
Fam therapy w/patient	$5,321,729	74,590	67,588	$1.86	$71.35	$78.74
Indiv Skills Training	$240,524	10,536	106,960	$0.08	$22.83	$2.25
Neuropsychological Testing	$0	-	-	$0.00		
Outpatient E/M	$2,648,125	42,191	35,965	$0.92	$62.77	$73.63
Psych Diag Eval	$3,365,439	39,907	33,225	$1.17	$84.33	$101.29
Psych Rehab Service	$8,747,034	89,572	639,645	$3.05	$97.65	$13.67
Psych Testing	$0	-	-	$0.00		
Psych. Diag Eval, w/ Med Services	$63,584	958	512	$0.02	$66.36	$124.26
Psytx Complex Interactive	$304,491	85,432	73,694	$0.11	$3.56	$4.13
Supportive Living	$0	1	-	$0.00	$0.00	
Targeted Case Management	$3,589,687	59,707	289,899	$1.25	$60.12	$12.38
Therapy w/ Patient+Fam 30 Min	$819,783	34,375	19,921	$0.29	$23.85	$41.15
Therapy w/ Patient+Fam 45 Min	$20,202,324	382,001	329,765	$7.05	$52.89	$61.26
Therapy w/ Patient+Fam 60 Min	$2,520,568	38,511	30,457	$0.88	$65.45	$82.76
H0004 - Behavioral health counseling and therapy	$701,853	15,377	54,027	$0.24	$45.64	$12.99
H0005 - Alcohol/drug services; group counseling	$1,886,830	39,392	282,262	$0.66	$47.90	$6.68
H0032 - Mental Health service plan development	$806,281	16,121	46,408	$0.28	$50.01	$17.37
T1013 - Sign language or oral interpretive services	$4,075,201	65,812	405,704	$1.42	$61.92	$10.04
T1015 - Clinical visit	$8,901,098	56,926	52,200	$3.11	$156.36	$170.52
Community Reinvestment - Peer Support	$7,536,536	76,067	549,837	$2.63	$99.08	$13.71
Community Reinvestment - Family Support	$1,067,082	14,722	77,883	$0.37	$72.48	$13.70
Psychotherapy for Crisis	$0	300	-	$0.00	$0.00	
Neurobehavioral Exam	$35,966	741	470	$0.01	$48.54	$76.55
Behavioral Modification Service	$5,894	187	637	$0.00	$31.52	$9.25
Functional Assessment Tool	$78,657	1,898	2,432	$0.03	$41.43	$32.34
Behavioral Health Day Treatment	$31,043	178	657	$0.01	$174.15	$47.22
Intensive Home and Community Based Service	$4	5	1	$0.00	$0.84	$4.17
Partial Hospitalization	$0	1	-	$0.00	$0.00	
Crisis Intervention	$131,229	1,559	7,000	$0.05	$84.20	$18.75
Other YES Services	$33,005	941	2,037	$0.01	$35.08	$16.21
Crisis Center Services	$0	25	-	$0.00	$0.00	
Total MH Groupings	$77,639,980	1,209,837	3,247,478	$27.10	$64.17	$23.91
Total MH Not Mapped	$10,461,798	206,707	744,437	$3.65	$50.61	$14.05
Total Services For Capitation	**$88,101,778**	**1,416,544**	**3,991,915**	**$30.75**	**$62.19**	**$22.07**
Community Reinvestment - Community Transition Support	$121	7	8	$0.00	$17.21	$15.00
Total Services Excluded For Capitation	$121	7	8	$0.00	$17.21	$15.00
Total Services Included in Data	**$88,101,899**	**1,416,551**	**3,991,923**	**$30.75**	**$62.19**	**$22.07**

(1) Incurred 1/1/2019 - 12/31/2019, paid through 3/31/2020. Amounts are shown with completion factor applied.

Appendix B-2
Idaho Department of Health and Welfare
Behavioral Health Plan
Dual Historical Data Summaries for Rate Development: January 1, 2019 - December 31, 2019

Average Members: 14,953

	CY19					
	Paid	**Procedures**	**Units**	**PMPM**	**Paid/Proc**	**Paid/Unit**
Community Reintegration	$0	-	-	$0.00		
E/M - Therapy - Addl 30 Min	$2,985	378	110	$0.02	$7.89	$27.12
Eval - Nontherapist	$31,617	479	1,856	$0.18	$65.97	$17.04
Fam therapy w/o patient	$21,770	358	292	$0.12	$60.73	$74.47
Fam therapy w/patient	$87,172	1,555	1,272	$0.49	$56.06	$68.51
Indiv Skills Training	$116,717	5,623	52,458	$0.65	$20.76	$2.22
Neuropsychological Testing	$0	-	-	$0.00		
Outpatient E/M	$142,543	5,929	4,751	$0.79	$24.04	$30.01
Psych Diag Eval	$158,085	2,528	2,024	$0.88	$62.52	$78.11
Psych Rehab Service	$1,507,718	18,563	110,207	$8.40	$81.22	$13.68
Psych Testing	$0	-	-	$0.00		
Psych. Diag Eval, w/ Med Services	$1,554	113	49	$0.01	$13.74	$31.69
Psytx Complex Interactive	$5,078	1,993	1,292	$0.03	$2.55	$3.93
Supportive Living	$0	-	-	$0.00		
Targeted Case Management	$722,418	12,929	59,264	$4.03	$55.88	$12.19
Therapy w/ Patient+Fam 30 Min	$71,963	3,636	2,428	$0.40	$19.79	$29.64
Therapy w/ Patient+Fam 45 Min	$1,556,731	38,044	31,054	$8.68	$40.92	$50.13
Therapy w/ Patient+Fam 60 Min	$159,065	4,219	3,259	$0.89	$37.71	$48.81
H0004 - Behavioral health counseling and therapy	$70,103	1,393	5,425	$0.39	$50.31	$12.92
H0005 - Alcohol/drug services; group counseling	$228,330	4,785	34,314	$1.27	$47.71	$6.65
H0032 - Mental Health service plan development	$111,760	1,995	6,194	$0.62	$56.03	$18.04
T1013 - Sign language or oral interpretive services	$26,950	494	2,660	$0.15	$54.50	$10.13
T1015 - Clinical visit	$618,281	6,540	4,946	$3.45	$94.54	$125.01
Community Reinvestment - Peer Support	$2,103,536	23,216	153,505	$11.72	$90.61	$13.70
Community Reinvestment - Family Support	$354	36	26	$0.00	$9.84	$13.63
Psychotherapy for Crisis	$0	27	-	$0.00	$0.00	
Neurobehavioral Exam	$228	26	17	$0.00	$8.76	$13.40
Behavioral Modification Service	$0	3	-	$0.00	$0.00	
Functional Assessment Tool	$11,750	250	340	$0.07	$47.07	$34.58
Behavioral Health Day Treatment	$0	-	-	$0.00		
Intensive Home and Community Based Service	$0	-	-	$0.00		
Partial Hospitalization	$0	-	-	$0.00		
Crisis Intervention	$29,609	341	1,819	$0.17	$86.76	$16.28
Other YES Services	$1,529	77	101	$0.01	$19.86	$15.14
Crisis Center Services	$0	4	-	$0.00	$0.00	
Total MH Groupings	$7,787,847	135,536	479,662	$43.40	$57.46	$16.24
Total MH Not Mapped	$547,672	21,053	37,540	$3.05	$26.01	$14.59
Total Services For Capitation	**$8,335,519**	**156,589**	**517,202**	**$46.45**	**$53.23**	**$16.12**
Community Reinvestment - Community Transition Support	$0	2	-	$0.00	$0.00	
Total Services Excluded For Capitation	$0	2	-	$0.00	$0.00	
Total Services Included in Data	**$8,335,519**	**156,591**	**517,202**	**$46.45**	**$53.23**	**$16.12**

(1) Incurred 1/1/2019 - 12/31/2019, paid through 3/31/2020. Amounts are shown with completion factor applied.

Attachment 2 - 202107 - 202206 Behavioral Health Rate Certification

Idaho Behavioral Health Plan Capitation Rate Development State Fiscal Year 2022

Prepared for:
Idaho Department of Health and Welfare

Prepared by:
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Appendices

M1. EXECUTIVE SUMMARY

INTRODUCTION

The Idaho Department of Health and Welfare (IDHW) retained Milliman, Inc. (Milliman) to develop actuarially sound behavioral health capitation rates for the Idaho Behavioral Health Plan (IBHP) as part of the overall Medicaid program. This report outlines the data, assumptions, and methodology used in the state fiscal year (SFY) 2022 capitation rate development for the legacy Medicaid-only members, the dual Medicaid and Medicare eligible members not enrolled in other managed care programs, and the expansion Medicaid-only members. The legacy members include all children and adults that are not considered as expansion, and are not of a dual eligible status. The SFY 2022 contract covers the July 1, 2021 – June 30, 2022 time period.

Beginning on September 2013, Optum began providing managed care to Medicaid eligible clients through IBHP and has historically received two capitation rates identified as dual and non-dual. IBHP covers most professional outpatient mental health services not in a facility, including family therapy, psychiatric rehab services, targeted case management, and therapy with patient and family. IBHP is mandatory for all eligible Medicaid clients, except those dual eligible members enrolled in the Medicare-Medicaid Coordinated Plan (MMCP) or the Idaho Medicaid Plus (IMPlus) programs.

Beginning January 2020 Optum also began to include Medicaid expansion members under managed care. For this population a third capitation rate was added, expansion, and certified separately. The following certification addresses the capitation rates for all three populations: legacy (traditional Medicaid-only members), duals (members eligible for both Medicaid and Medicare), and expansion. The state has reviewed and confirmed the aid category assignment for each of these rate cells.

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2020-2021 Medicaid Managed Care Rate Development Guide (CMS Guide), published July 2020:

> The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
>
> The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
>
> The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

CMS Guide Index [Section I.1.B]

We indexed each section of this report to the corresponding section of the “2020-2021 Medicaid Managed Care Rate Development Guide”. For example, the contents within the brackets above refer to Section I, subsection 1 “General Information”, bullet B “Appropriate Documentation”. This notation appears in the table of contents as well as the body of this rate certification.

CAPITATION RATES

Table 1 reflects the monthly capitation rates effective July 1, 2021 through June 30, 2022 (SFY 2022) by rate cell.

Table 1
Idaho Department of Health and Welfare
Behavioral Health Plan
July 1, 2021 - June 30, 2022 Rates

	Contracted Rate PMPM
Legacy	$43.73
Duals	$61.07
Expansion	$52.53

APPENDICES

Appendix A details the development of these IBHP rates.

Appendix B shows the historical base period experience for the legacy, dual, and expansion populations by IBHP service category.

M2. MEDICAID MANAGED CARE RATES [SECTION I]

GENERAL INFORMATION [SECTION I.1]

Rate Development Standards [Section I.1.A]

Rating Period [Section I.1.A.i]:

This rate certification is for a 12-month rating period effective July 2021 through June 2022.

Items included in an acceptable rate certification [Section I.1.A.ii]:

a. *A letter from the certifying actuary:*

See Section M6 for the rate certification at the end of this report.

b. *The final and certified capitation rates for all rate cells:*

The final and certified rates eligible for federal financial participation can be found in Table 1.

Appendix A steps through the adjustments to reach the rate for each rate cell.

- Calendar Year (CY) 2020 data collected from Optum and provided by IDHW was summarized by rate cell and limited to covered services and populations.
- The following adjustments are applied to project these claim costs to the July 2021 thru June 2022 rate period:
    - Adjustment for annual utilization and unit cost trends to SFY 2022.
    - Adjustment for the impact of the COVID-19 pandemic.
    - Adjustment for retrospective membership changes.
    - Adjustment for the ramp-up of the expansion program.
    - Addition for expected costs of new services not covered in the CY 2020 base data period that are covered in SFY 2022.
- A 13.4% non-benefit expense load is applied for the dual and legacy populations and a 13.3% non-benefit expense load is applied for the expansion population.

Additional information regarding the development of the behavioral health capitation rates is detailed in this report.

c. *Descriptions of the program:*

(i) A summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

(A) The types and numbers of managed care plans included in the rate development:

For this program, the state is currently served by one managed care provider (Optum). Prior to Optum, these services were provided on a fee-for-service basis.

(B) A general description or list of the benefits that are required to be provided by the managed care plan or plans:

Optum is required to provide certain non-facility behavioral health services covered under the state plan. The State Plan for behavioral health services covers a variety of core provider services. Historical experience is summarized by service category and shown in Appendix B. The covered services do not vary by covered population. All covered services are consistent with the State Plan.

In addition to the required state plan services, Optum chooses to provide some services as “value add” or “community reinvestment” services. These services were originally provided by Optum as a way of spending reserve funds leftover from prior years. The one current community reinvestment service is for Community Transition Support (HCPC = H2015). This service is excluded in our claim cost projections.

(C) The areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

Optum has been providing statewide coverage since September 2013. Optum also covers the statewide expansion population effective January 2020 (when expansion coverage began in Idaho).

(ii) Rating period:

The rating period covered by this rate certification is July 2021 through June 2022.

(iii) Covered populations:

Legacy, dual, and expansion populations are covered under this program. The legacy population includes all non-dual, non-expansion members, including adults, not eligible for expansion, and children. The dual population excludes those members enrolled in either the Medicare-Medicaid Coordinated Plan (MMCP) or the Idaho Medicaid Plus (IMPlus) programs. Expansion members are considered as a separate rate cell, and have different risk sharing provisions included in the contract.

(iv) Eligibility and enrollment criteria:

Enrollment in IBHP is mandatory for the covered populations.

(v) Special contract provisions:

Not applicable.

(vi) Retroactive Adjustments:

Not applicable.

Differences between covered populations [Section I.1.A.iii]:

Any differences among capitation rates according to covered populations are based on valid rate development standards (such as differences in historical experience) and are not based on the rate of federal financial participation associated with the covered populations.

Cross-subsidization [Section I.1.A.iv]:

Capitation rates were developed such that payments from any rate cell do not cross-subsidize payments from any other rate cell.

Consistency of effective dates [Section I.1.A.v]:

The effective dates for changes to the Medicaid managed care program (including eligibility, benefits, and payment rate requirements) are consistent with the assumptions used to develop the capitation rates. These changes have been summarized in Section M1. Executive Summary, with detail included within the assumption documentation sections.

Considerations for MLR standards [Section I.1.A.vi]:

The capitation rates for each base behavioral health population includes a 13.4% non-benefit cost assumption for the legacy and dual populations and a 13.3% non-benefit cost assumption for the expansion population.

Based on these assumptions, we project managed care entities will achieve MLRs above 85%.

Additionally, Optum is required to provide periodic reports of Medical Loss Ratio (MLR) results, in a timely manner established by the DWH, and in accordance with CMS' methodology [Id. § 438.8(e)]. Reports must be submitted no later than within 12 months of the end of a year for which the MLR pertains. All third party vendors providing claims adjudications activities are required to provide all underlying data associated with MLR reporting to the vendor within 180 days of the end of the MLR reporting year, or within 30 days of a request by the vendor (whichever comes sooner) to calculate and validate the accuracy of MLR reporting.

Considerations for CMS [Section I.1.A.vii]: *As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:*

a. *all adjustments are reasonable, appropriate, and attainable in the actuary's judgment.*

   All adjustments applied during the capitation rate development have been documented herein and are certified as part of the overall rates as reasonable, appropriate, and attainable by the certifying actuary.

b. *adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.*

   We have not made additional adjustments outside the rate setting process documented herein.

c. *consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell.*

   It is our understanding that the final contracted rates paid to the managed care entities for each rate cell are consistent with the capitation rates included in Table 1.

Certification period [Section I.1.A.viii]:

Rates are effective and certified for July 2021 through June 2022.

Procedures for rate certifications for rate and contract amendments [Section I.1.A.ix]:

Not applicable.

Appropriate Documentation [Section I.1.B]

Documentation detail required [Section I.1.B.i]: *States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:*

a. *Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources.*

   The base claims encounter data used to develop the capitation rates were from calendar year (CY) 2020 (January 1, 2020 – December 31, 2020), including run-out claims through February 2021. The State of Idaho provided this encounter data from Optum for the covered populations. We were able to identify the same populations from the capitation files (provided directly by the IDHW), which identified the populations covered by this contract. We determined that these sources of experience were a credible set of base data for all covered populations.

b. *Assumptions made:*

   Details supporting all assumptions are provided throughout this document. The following adjustments have been applied during rate development:

   - Utilization and unit cost trends from base period to rate period
   - Impact of the COVID-19 pandemic
   - Retrospective membership changes
   - Ramp-up adjustment for the expansion population
   - Additional considerations for new services
   - Non-Benefit expenses

   Methodology applied in developing assumptions and adjustments are described throughout this document where assumptions are identified.

Rate Ranges [Section I.1.B.ii]

Rates are based on point estimates and ranges were not used.

Rate certification index [Section I.1.B.iii]

The table of contents of this document serves as the rate certification index.

Differences in FMAP [Section I.1.B.iv]

There are no rate development assumptions or methodologies that differ based on the rate of FMAP.

Managed care program additional documentation requests [Section I.1.B.v]

a. *Comparison to previous certified rates*

The change in the SFY 2022 rates compared to the prior certified rates for January 2021 through June 2021 are shown in the table below.

Table 2
Idaho Department of Health and Welfare
Behavioral Health Plan
Change in Rates

	Current Rate	Prior Rate	Rate Change
Legacy	$43.73	$42.04	4.0%
Duals	$61.07	$59.69	2.3%
Expansion	$52.53	$48.97	7.3%

These rate changes are reasonable, as all populations continue to show increases on a PMPM basis for the cost of benefits covered. The expansion program just began in CY 2020 and the first year of experience from this program has trended higher than expected with no slow-down in utilization due to the COVID-19 pandemic, so the percentage rate increase for this population is higher than the rate increase for the other populations.

b. *Description of any material changes to the rates or rate development process not addressed elsewhere*

Not applicable.

Known Amendments [Section I.1.B.vi]

Not applicable

Data [Section I.2]

Rate Development Standards [Section 1.2.A]

Base data standards [Section I.2.A.i]:

a. *Validated data and audited financial reports*

Optum provided validated encounter data for use in rate development, specific to the covered population, which was a starting point for this rate build. We have not audited or verified this data and other information, but we did compare data to financial summaries provided by Optum for reasonableness

b. *Appropriate base data period*

We constructed rates using CY 2020 claims and capitation payment data received from Optum and the IDHW, which was the most recent complete year of data available at the time of the analysis.

c. *Appropriate base data population*

We derived the base data from the same base behavioral health population covered under this certification.

d. *Alternative data sources*

Not applicable.

Appropriate Documentation [Section I.2.B]

Description of data requested [Section I.2.B.i]: *In accordance with 42 CFR §438.7(b)(1), the rate certification must include:*

a. *A description of base data requested and used by the actuary for the rate setting process, including:*

(i) A summary of the base data that was requested by the actuary.

Detailed claims, eligibility, and capitation files through CY 2020 were requested along with financial reports through February 2021. We also requested information related to fee schedule changes and benefit changes.

(ii) A summary of the base data that was provided by the state.

All requested data was provided.

(iii) An explanation of why any base data requested was not provided by the state.

Not applicable.

Description of data used to develop rates [Section I.2.B.ii]: *The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including:*

a. *Description of the data.*

We utilized managed care encounter data and health plan financial data.

We used the CY 2020 encounter data for the base period with runout through February 2021. More recent encounter data was not yet available at the time of our analysis.

We received all data related to the base behavioral health population from Optum and the IDHW. Some assumptions were developed using information based on our experiences with other states and Milliman research.

There are no sub-capitated costs in the base experience period.

b. *Data availability and quality:*

(i) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:

(A) completeness of the data.

(B) accuracy of the data.

(C) consistency of the data across data sources.

We have summarized the base period of data by HCPCS code based behavioral health groupings and eligibility population. Our analysis excluded any duplicate records, claims for non-covered populations, and claims for non-covered services. From the data, we were able to calculate historical utilization and unit cost values, as well as the resulting PMPM costs. These summaries allow us to evaluate the data for reasonableness and compare to prior years' data and other data sources. We were able to determine the data is complete, accurate, and consistent, and have no concerns about the data. Data was not provided with the ultimate run-out of claims, so an adjustment was made to complete the base data for claims incurred but not paid with an overall completion factor of 0.986.

(ii) a summary of the actuary's assessment of the data.

As the certifying actuary, I have assessed the quality of available data to be sufficient for the purpose of developing projected capitation rates effective during the contract period for the legacy, dual and expansion populations.

All data were reviewed at several levels by consultants, actuaries, and data analysts who have experience with Medicaid data. We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent.

(iii) any other concerns that the actuary has over the availability or quality of the data.

Not applicable.

c. *Data appropriateness: a description of how the actuary determined what data was appropriate to use for the rating period, including:*

(i) if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.

Not applicable. Recent managed care encounter data for the covered populations was used.

(ii) if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.

Not applicable.

d. *Reliance on a data book:*

Not applicable.

Description of data adjustments [Section I.2.B.iii]:

a. *Credibility:*

Not applicable.

b. *Completion factors:*

Data was not provided with the ultimate run-out of claims, so an adjustment was made to complete the base data for claims incurred but not paid. Historical data going back four years was split into lag triangles by incurred and paid month. A reserve model was then used to predict future claims runout based off historical completion patterns. The results of this model were reviewed for reasonableness and small overrides were made to smooth results. Because the adjustment for completion was calculated and applied based on incurred month, the overall completion factor for each population varies from 0.984 to 0.988 depending on the mix of claims by date, with the aggregate factor across all populations at 0.986.

c. *Data errors:*

Not applicable.

d. *Program changes:*

Effective January 1, 2021, Optum began covering the drug portion of Opioid Treatment Program (OTP) services, in addition to the therapy costs that have historically been covered. Cost projections for these services were provided by Optum based on their CY 2020 experience of non-drug OTP services and the expected incremental cost of the drugs. We reviewed these projections for reasonableness and converted these costs into PMPMs. These OTP services add approximately $0.29 PMPM to the legacy rate, $0.28 PMPM to the dual rate and $1.07 PMPM to the expansion rate over the twelve-month rate period. These amounts are consistent with the projections provided for the prior certification.

e. *Exclusions:*

Not applicable.

PROJECTED BENEFIT COSTS AND TRENDS [SECTION I.3]

Rate Development Standards [Section I.3.A]

Services in final rates [Section I.3.A.i]:

Final capitation rates are based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

Variations in assumptions [Section I.3.A.ii]:

Variations in the assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

Development of benefit cost trends [Section I.3.A.iii]:

See section I.3.B.iii.

In-lieu-of services [Section I.3.A.iv]:

Not applicable.

Costs associated with IMDs [Section I.3.A.v]:

Not applicable.

Appropriate Documentation [Section I.3.B]

Projected benefit costs [Section I.3.B.i]:

Appendix A shows the development of the projected benefit costs.

Development of projected benefit costs [Section I.3.B.ii]:

a. *Description of the data, assumptions and methodologies used to develop the projected benefit costs.*

We relied on data supplied by Optum and the IDHW, conversations with the IDHW, internal Milliman research and publicly available data sources to develop assumptions to adjust the base period data and produce projected benefit cost estimates.

See Section 1.3.B.iii for additional information regarding the data, assumptions and methodologies used to develop the trends.

b. Material changes to the data, assumptions and methodologies since the last rate certification.

We now have a full year of experience specific to the expansion population that we are able to use for the base period in the development of that rate cell's capitation rate.

c. The amount of overpayments to providers and a description of how the state accounted for this in rate development.

Not applicable.

Trends [Section I.3.B.iii]:

a. *This section must include:*

(i) Data and assumptions used to develop trends:

(A) Descriptions of data and assumptions.

Trend adjustments were applied to the base data on a cost per unit and utilization per thousand basis to project to the effective period. The table below presents applied annual trends.

Table 3
Idaho Department of Health and Welfare
Behavioral Health Plan
Annual Trend - All Services

	Cost/Unit Trend	Util/1,000 Trend	PMPM Trend
Legacy	0.5%	2.0%	2.5%
Duals	0.6%	2.0%	2.6%
Expansion	1.1%	2.0%	3.2%

We selected these trend assumptions based upon our review of a number of different sources including but not limited to program specific experience.

First, unit cost trends were set based on known fee schedule changes and known changes to FQHC reimbursement. A number of services had reimbursement rates increased from the 2020 to the 2021 fee schedule. The 2020 costs for these services were repriced using the 2021 fee schedule and the additional costs were added to the base period through the unit cost trend, Also, Optum informed us that they are changing reimbursement for FQHCs in 2021. They provided us an estimate of how much this would affect costs in SFY 2022, which we also incorporated into the unit cost trend. While the reimbursement changes are the same for each population, the mix of services utilized by each population differs, and as such, the implied cost/unit trend varies by population.

Next, utilization trends are set based on our review of historical Idaho Medicaid behavioral health data and various Milliman manuals (Ages 65 and Over Health Cost Guidelines, Commercial Managed Care Rating Model).

Note an additional one-time 2.5% load was applied to reflect additional increases in utilization expected due to the COVID-19 pandemic. We arrived at this assumption through discussions between Milliman, Optum, and IDHW.

(B) Reliance on experience

While we reviewed historical program experience, we relied on a number of sources to develop our trend assumption, as described above.

(ii) Methodologies used to develop trends:

Unit cost trends were developed using known fee schedule changes and known changes to FQHC reimbursement as described above.

Utilization trends were developed using a number of different sources. Historical trends were relied upon partially in setting trends for this program. However, due to some newly covered services and changes in service mix over the years, historical trends cannot be relied upon completely. Thus, we also used various Milliman manuals (Ages 65 and Over Health Cost Guidelines, Commercial Managed Care Rating Model) to inform the utilization trend assumption.

While the trend methodology is consistent for all populations, the unit cost trend assumptions differ for each population based on mix of services with fee schedule changes and the amount of services from FQHC's in the base period.

(iii) Comparisons to historical trends:

Since SFY 2017, historical PMPM trends have been mostly negative for the dual population and positive for the legacy population. The increases in the legacy population are driven in part due to the additional services covered and fee schedule increases over the last few years. The decreases in the dual population are mostly driven by large changes in enrollment mix as many higher cost eligibles moved to other programs. The expansion population only started in 2020, so no historical trends are yet available.

Table 4
Idaho Department of Health and Welfare
Behavioral Health Plan
Historical Trends

	Dual			Legacy		
Period	Util/1000	Unit Cost	PMPM	Util/1000	Unit Cost	PMPM
SFY17	4,813.51	$13.43	$64.63	1,123.34	$21.41	$24.05
SFY18	4,126.49	$14.47	$59.72	1,113.76	$22.65	$25.23
SFY19	3,433.82	$15.51	$53.27	1,281.76	$22.18	$28.43
SFY20	2,744.19	$15.24	$41.83	1,686.38	$19.64	$33.11
Partial SFY21	2,941.99	$17.16	$50.49	1,713.86	$20.59	$35.30
SFY 18/17	-14.3%	7.8%	-7.6%	-0.9%	5.8%	4.9%
SFY 19/18	-16.8%	7.2%	-10.8%	15.1%	-2.1%	12.7%
SFY 20/19	-20.1%	-1.7%	-21.5%	31.6%	-11.5%	16.5%
SFY 21/20	7.2%	12.6%	20.7%	1.6%	4.9%	6.6%

(iv) Outlier and negative trends:

No negative or outlier trends were applied.

b. *Components of trend:*

As described above, trend is applied separately for utilization and cost increases.

c. *Variations in trend:*

Trend assumptions vary by population only for unit cost trends. This is due to a different mix of services in each population that is subject to the fee schedule increases and a different amount of FQHC claims in each population that will have increased reimbursement in SFY 2022.

d. *Other material adjustments to trend:*

In addition to our standard trend analysis, we also considered potential impact of the emerging situation regarding the COVID-19 pandemic. There is uncertainty regarding the impact of COVID-19 on future claims costs, including whether the pandemic will increase or decrease costs in SFY 2022. For behavioral health services included under this contract, we reviewed monthly costs and utilization throughout CY 2020 and have not observed any notable amount of deferred or avoided services through CY 2020, with costs instead appearing to trend at an even higher rate in the experience compared to CY 2019. Additionally, literature such as the Kaiser Family Foundation Issue Brief "The Implications of COVID-19 for Mental Health and Substance Use"[1] note the pandemic is likely to have both long-and short-term adverse implications for mental health and substance use. Therefore, in addition to the trend factors above, a 1.025 one-time adjustment was applied to projection period utilization to account for expected utilization increases in 2022 due to the COVID-19 pandemic. This adjustment was applied to all populations.

Additionally, a one-time adjustment was applied for the expansion population to account for the ramp-up of the program in 2020. The expansion population only began to be covered in Idaho effective 1/1/2020, and our review of the data showed that 2020Q1 costs for the expansion program were significantly lower than the rest of the months in 2020. Since the program had just started, the 2020Q1 costs are less reliable than the other months in 2020. Thus, we calculated a one-time adjustment to the CY 2020 base period data to bump up costs to be in line with the 2020Q2 – 2020Q4 PMPM experience level. This adjustment increased the base period costs by 5.1%.

[1] Source published August 21, 2020: https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Because the other populations have many years of data under managed care, no ramp-up adjustment is applied for the other populations.

e. *Other non-material adjustments to trend:*

Not applicable.

Adjustments due to MHPAEA [Section I.3.B.iv]:

Not applicable.

In-lieu-of services [Section I.3.B.v]:

Not applicable.

Retrospective eligibility periods [Section I.3.B.vi]:

a. *the managed care plan's responsibility to pay for claims incurred during the retroactive eligibility period.*

Optum is required to pay claims incurred during the retroactive eligibility period, even though they do not receive a capitation payment for that member.

b. *how the claims information are included in the base data.*

The base data is limited to only include claims that correspond to members with a valid capitation record in that month. Since retrospective eligibility periods are not paid by a capitation the base data does not include the claims information associated with retrospective eligibility.

c. *how the enrollment or exposure information is included in the base data.*

The base data is limited to only include enrollment for members with a valid capitation record in that month. Since retrospective eligibility periods are not paid by a capitation the base data does not include the exposure information associated with retrospective eligibility.

d. *how the capitation rates are adjusted to reflect the retroactive eligibility period, and the assumptions and methodologies used to develop those adjustments*

For SFY 2022 rate setting, a one-time adjustment factor was applied for retroactive membership changes for all populations. There are certain members without a capitation record that Optum paid claims for and these claims are included as covered costs for eligible members under the contract. Because no capitation record exists for these members, these costs were not included in our base period data. Based on a comparison of the detailed encounter data to the financial summaries, we determined that the excluded costs from retroactive eligibility periods was not evenly spread over all the populations. Thus, we took the total claims excluded due to no matching membership capitation record and allocated by rate cell based on the difference between the detailed encounter data and the financial summaries for each rate cell in CY 2020. These excluded costs represented 0.9% of the total paid dollars for the legacy population, 4.9% of the total paid dollars for the dual population and 2.6% of the total paid dollars for the expansion population (a 1.4% impact across all populations). The adjustment factors add back in these costs as similar levels of these claims are expected in SFY 2022.

Changes to covered benefits or services [Section I.3.B.vii]:

a. *More or fewer state plan benefits covered by Medicaid managed care.*

See Section I.2.B.iii.(d).

b. *Any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d).*

See Section I.3.B.ii.(c).

c. *Requirements related to payments from health plans to any providers or class of providers.*

See Section I. 4.D.

d. *Requirements or conditions of any applicable waivers.*

We are not aware of any new requirements that would be included as covered benefits under the managed care entity.

e. *Requirements of conditions of any litigation to which the state is subjected.*

We are not aware of any requirements or conditions of any litigation to which the state is subjected.

Impact of changes to covered benefits or services [Section I.3.B.viii]:

See section I.2.B.(iii).(d).

SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT [SECTION I.4]

Incentive Arrangements [Section I.4.A]

Rate Development Standards [Section I.4.A.i]

See section 1.4.A.ii.

Appropriate Documentation [Section I.4.A.ii]

There are no withhold or incentive arrangements for all populations.

Withhold Arrangements [Section I.4.B]

Rate Development Standards [Section I.4.B.i]

See section 1.4.B.ii.

Appropriate Documentation [Section I.4.B.ii]

Not applicable

Risk-Sharing Mechanisms [Section I.4.C]

Rate Development Standards [Section I.4.C.i]

See section 1.4.C.ii.

Appropriate Documentation [Section I.4.C.ii]

Consistent with prior years, the contract for the legacy and dual populations includes an 85% minimum medical loss ratio (MLR) requirement. The MLR limits the amount of profit that Optum is able to achieve on the total combined dual and legacy population (not including expansion). If Optum has a MLR less than 85%, the unspent claim dollars must be placed in a reserve account (or remitted to the state). This money must be reinvested in the program, in the form of community reinvestment (community health initiative) or remitted to the state.

Unlike the contract for the legacy and dual populations, the contract for the expansion population continues to include a two-sided risk sharing arrangement in the form of a medical loss ratio (MLR) Settlement. Retrospectively, the MLR settlement payment will settle for the actual program experience. The target MLR is 88% with a 3% corridor within which no adjustments will be made to the rates. If the MLR is lower than 85%, then Optum shall remit 100% of the difference in total applicable revenue to achieve an 85% MLR. If the MLR is above 91%, the IDHW will remit to Optum 100% of the difference in total applicable revenue to achieve a 91% MLR.

Per the contract, the calculation of the MLR is defined as the sum of the Contractor's incurred claims; and expenditures on activities that improve health care quality; and fraud prevention activities (limited to zero point five percent (0.5%) of the Contractor's premium revenues); divided by premium revenue as defined in 42 CFR § 438.8(a) through (i).

Delivery System and Provider Payment Initiatives [Section I.4.D]

Rate Development Standards [Section I.4.D.i]

See section 1.4.D.ii.

Appropriate Documentation [Section I.4.D.ii]

We understand Optum continues to implement their “Achievements in Clinical Excellence” (ACE) program in Idaho. This program identifies clinicians and groups delivering outstanding care based on regionally adjusted nationwide metrics, with identified providers receiving an extra 3% over the fee schedule. We understand this fee schedule increase is on top of any fee schedule increases otherwise given. This program has been in effect for a number of years already and no major changes are expected in SFY 2022 that would affect capitation rates. Our understanding is that the state did not require Optum make these additional incentive payments and that the ACE program was developed by and is run completely by Optum, without state direction, thus these are not state directed payments. There are no other additional directed payments in the program that are not addressed in this certification and there are not any requirements regarding the reimbursement rates that Optum must pay to any providers.

Pass-Through Payments [Section I.4.E]

Rate Development Standards [Section I.4.E.i]

Not applicable.

Appropriate Documentation [Section I.4.E.ii]

Not applicable.

PROJECTED NON-BENEFIT COSTS [SECTION I.5]

Rate Development Standards [Section I.5.A]

See Section I.5.B.

Appropriate Documentation [Section I.5.B]

Description of non-benefit cost projection [Section I.5.B.i]:

a. *Description of data, assumptions and methodologies*

Rates include a non-benefit expense load of 13.4% of premium for the legacy and non-dual populations and 13.3% of premium for the expansion population. This load accounts for the administrative costs associated with a managed care program and margin.

The administrative portion was set in line with Optum's historical SFY 2019 and 2020 reported costs of 12.7%. We understand Optum expects administrative costs in SFY 2022 to be similar to this historical experience. However, beginning in CY 2020, telehealth transmission fee payments have become a higher percentage of total benefit costs and Optum does not believe additional administrative costs are needed to cover this portion of the projected benefit costs. Therefore, the administrative cost load for each population has been adjusted slightly downward to account for this, with the magnitude of the adjustment driven by the telehealth transmission fee costs included in the historical base period data for each population. As a result, the ultimate administration expense allocation varies slightly by population based on the amount of telehealth services utilized by each population.

The administrative allowance is inclusive of projected quality improvement related costs, as well as taxes and fees. The load based on the following non-benefit cost assumptions:

• Administration expense allocation: 12.4% of premium for the legacy and non-dual populations and 12.3% of premium for the expansion population.

• Underwriting gain: 1.0% of premium.

b. *Material changes to the data, assumptions and methodologies since the last rate certification.*

Not applicable

c. *Other material adjustments*

Not applicable.

Categories of non-benefit costs [Section I.5.B.ii]:

See Section I.5.B.i.

Historical non-benefit costs [Section I.5.B.iii]:

Historical non-benefit costs for SFY 2017 through SFY 2020 were provided by Optum and divided into administrative costs, QI/HIT costs, and taxes and fees. These amounts are shown in the table below as a percent of revenue, net of withhold.

Table 5 Idaho Department of Health and Welfare Behavioral Health Plan Historical Non-Benefit Costs				
	Administrative	QI/HIT	Taxes and Fees	Total
SFY 2017	5.7%	2.2%	3.4%	11.3%
SFY 2018	7.2%	2.5%	2.7%	12.3%
SFY 2019	7.5%	2.4%	2.7%	12.7%
SFY 2020	8.7%	2.7%	1.3%	12.7%

Health Insurance Providers Fee [Section I.5.B.iv]:

The administrative allowance does not include for the costs of the Health Insurance Providers Fee (HIF). Our understanding is that Optum is not required to pay this fee, and this fee is no longer in place for SFY 2022.

RISK ADJUSTMENT AND ACUITY ADJUSTMENTS [SECTION I.6]

Rate Development Standards [Section I.6.A]

See Section I.6.B.

Appropriate Documentation [Section I.6.B]

Description of all prospective risk adjustment methodologies [Section I.6.B.i]:

Not applicable.

Description of all retrospective risk adjustment methodologies [Section I.6.B.ii]:

Not applicable.

Additional rate certification and supporting documentation requirements [Section I.6.B.iii]:

Not applicable.

Description of acuity adjustments [Section I.6.B.iv]:

No acuity adjustments were made. Because the program is statewide and mandatory for all eligible members, there are no adjustments made for favorable or adverse selection. Also, the base data reflects experience for a managed care environment. The services became capitated in September 2013, and we do not anticipate any additional managed care savings beyond what was realized through the base period. Our review of historical data shows that most savings were realized in the first couple years of the program. Therefore, no additional adjustment has been made for managed care savings.

M3. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS [SECTION II]

Not applicable. These services are not covered under this program.

M4. NEW ADULT GROUP CAPITATION RATES [SECTION III]

The new adult group capitation rates have been addressed in the sections above under the expansion rate cell.

M5. DATA RELIANCE AND CAVEATS

This document and its attached exhibits, appendices and data are intended for use by the IDHW in support of its SFY 2022 dual, legacy and expansion behavioral health capitation rates. This report may be shared with CMS for that purpose. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this presentation to other third parties. Similarly, third parties are instructed that they are to place no reliance upon this analysis prepared for the IDHW by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. The terms of Milliman's contract with the IDHW effective July 1, 2019 apply to this analysis and its use. Other parties receiving this report must rely upon their own experts in drawing conclusions about the data underlying the cost model. It is the responsibility of any insurance carrier to establish required revenue levels appropriate for their risk, management, and contractual obligations for the prospective population.

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual Optum experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis.

We have relied on data from numerous sources to compile this report. This report and associated analyses rely extensively on data provided by Optum and the IDHW. These data include, among other items, eligibility, capitation payment records, and encounters for both mental health benefits. We have not audited or verified this data, though we have compared some of the data provided to us to financial summaries provided by the IDHW in order to assess the reasonableness of the data. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review of the data to search for data values that are of questionable validity or for relationships which are materially inconsistent. Such a review was beyond the scope of our assignment.

Models used in the preparation of our analysis were applied consistently with their intended use. Where we relied on models developed by others, we have made a reasonable effort to understand the intended purpose, general operation, dependencies, and sensitivities of these models.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

M6. ACTUARIAL CERTIFICATION

I, Benjamin J. Diederich, am a Principal and consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Idaho Department of Health and Welfare (IDHW) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for Idaho's managed care behavioral health program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the twelve-month period of July 2021 to June 2022.

To the best of my information, knowledge and belief, for the July 2021 to June 2022 period, the capitation rates offered by the IDHW are actuarially sound and comply with the requirements of 42 CFR § 438.4, the CMS Managed Care Rate Setting Guide and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on ACOs, MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the ACO, MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the IDHW and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

_____

Benjamin J. Diederich, FSA, MAAA
Principal and Consulting Actuary

April 30, 2021

_____

Date

Appendix A
Idaho Department of Health and Welfare
Behavioral Health Plan
July 1, 2021 - June 30, 2022 Rate Development

	Idaho Medicaid Population		
	Legacy	**Duals**	**Expansion**
Base Year Data Average			
Base Period	CY2020	CY2020	CY2020
Average Members	232,638	6,597	78,021
Paid (1)	$97,727,076	$3,727,322	$35,962,757
Units (2)	4,876,424	231,157	1,758,093
Units/1,000	20,961	35,037	22,534
Cost/Unit	$20.04	$16.12	$20.46
PMPM	**$35.01**	**$47.08**	**$38.41**
Annual Trends			
Utilization Trend	1.020	1.020	1.020
Cost Trends	1.005	1.006	1.011
One-time Adjustments			
COVID-19 Adjustment	1.025	1.025	1.025
Retroactive Membership Adjustment	1.009	1.049	1.026
Ramp up Factor	1.000	1.000	1.051
Claim Projection			
Average Members	247,734	5,710	100,647
Units/1,000	22,332	38,809	25,648
Cost/Unit	$20.19	$16.26	$20.80
PMPM	**$37.58**	**$52.59**	**$44.47**
Additional Benefits PMPM			
OTP Bundle (starts 1/1/2021)	$0.29	$0.28	$1.07
PMPM w/Added Benefits	$37.87	$52.87	$45.53
Non-Benefit Assumptions			
Non-Benefit % of Total PMPM	13.4%	13.4%	13.3%
Total Certified Rate	**$43.73**	**$61.07**	**$52.53**

(1) Estimated incurred amount, adjusted for completion.
(2) HCPC reported units

Appendix B-1
Idaho Department of Health and Welfare
Behavioral Health Cost Model Summary
Legacy Non-Dual Population
Optum Encounters Incurred CY 2020, Paid through February 2021

Member Months:	2,791,654
Aggregate Completion Factor:	0.986

Service Description	HCPCS	Total Paid	Total Units	Utils/1,000	Unit Cost	Paid PMPM
Drug Tests	80305-80307	$163,407	6,337	27.2	$25.79	$0.06
Psychiatric Complex Interactive	90785	$236,326	64,547	277.5	$3.66	$0.08
Psychiatric Diagnositic Evaluation	90791, 90792	$2,980,226	35,773	153.8	$83.31	$1.07
Psychotherapy	90832-90834, 90836-90838	$24,179,965	469,562	2,018.4	$51.49	$8.66
Psychotheraypy for Crisis	90839, 90840	$114,440	1,550	6.7	$73.84	$0.04
Family Psychotherapy	90846, 90847	$6,588,519	95,156	409.0	$69.24	$2.36
Group Psychotherapy	90853	$163,955	10,152	43.6	$16.15	$0.06
Neurobehavioral Exam	96116, 96121	$24,009	606	2.6	$39.59	$0.01
Psychological Testing	96130-96133, 96136-96139, 96146	$1,668,517	37,498	161.2	$44.50	$0.60
Therapeutic Injection	96372	$37,325	2,217	9.5	$16.84	$0.01
Behavioral Modification Service	97151-97158, 0362T, 0373T	$529,217	65,808	282.9	$8.04	$0.19
Office Visit - New Patient	99201-99205	$343,926	2,963	12.7	$116.07	$0.12
Office Visit - Established Patient	99211-99215	$2,784,107	46,129	198.3	$60.35	$1.00
OTP Bundle	G2067, G2068, G2074	$0	-	-		$0.00
Other YES Services	G9007	$51,656	3,339	14.4	$15.47	$0.02
SUD Treatment Plan	H0001	$199,211	16,713	71.8	$11.92	$0.07
Drug/Alcohol Testing	H0003	$130,950	10,507	45.2	$12.46	$0.05
Individual Counseling	H0004	$816,088	69,358	298.1	$11.77	$0.29
Group Counseling	H0005	$1,940,633	315,217	1,355.0	$6.16	$0.70
Intensive OP Treatment	H0015 (1)	$638,574	5,519	23.7	$115.70	$0.23
Crisis Response	H0030	$30,052	1,056	4.5	$28.45	$0.01
CANS Assessment	H0031	$2,541,639	133,673	574.6	$19.01	$0.91
Individualized Skills Building Treatment Plan	H0032	$864,725	52,283	224.7	$16.54	$0.31
Partial Hospitalization	H0035 (2)	$1,554,234	3,887	16.7	$399.83	$0.56
Community Reintegration	H0036	$9,436	393	1.7	$24.03	$0.00
Peer Support	H0038	$7,325,534	561,364	2,413.0	$13.05	$2.62
Family Support	H0046	$634,979	50,314	216.3	$12.62	$0.23
Functional Assessment Tool	H1011	$175,059	9,946	42.8	$17.60	$0.06
Crisis Intervention	H2011	$135,375	5,402	23.2	$25.06	$0.05
Behavioral Health Day Treatment	H2012	$334,818	7,550	32.5	$44.35	$0.12
Individual Skills Training	H2014	$360,684	92,682	398.4	$3.89	$0.13
Psych Rehab Service	H2017	$10,950,326	854,967	3,675.1	$12.81	$3.92
Psychoeducational Services	H2027	$30,534	2,396	10.3	$12.74	$0.01
Intensive Home & Community Based Service	H2033	$0	-	-		$0.00
Unskilled Respite Care	S5150	$1,414,616	257,263	1,105.9	$5.50	$0.51
Intensive OP Psych Service	S9480 (3)	$144,947	1,524	6.6	$95.10	$0.05
Crisis Center Services	S9485	$691,143	2,212	9.5	$312.45	$0.25
Language Interpretation Services	T1013	$4,367,933	448,308	1,927.1	$9.74	$1.56
Telehealth Fee	T1014, Q3014	$2,790,444	155,519	668.5	$17.94	$1.00
Clinical Visit	T1015	$11,425,179	64,229	276.1	$177.88	$4.09
Targeted Case Management	T1017	$7,530,104	592,878	2,548.5	$12.70	$2.70
Transportation Reimbursement	T2002	$119,856	229,080	984.7	$0.52	$0.04
Not Mapped	Other	$704,412	90,546	389.2	$7.78	$0.25
Total Services For Capitation		**$97,727,076**	**4,876,424**	**20,961.4**	**$20.04**	**$35.01**
Community Reinvestment Services						
Community Transition Support	H2015	$240	43	0.2	$5.58	$0.00
Total Services Included in Data		**$97,727,316**	**4,876,467**	**20,961.6**	**$20.04**	**$35.01**

(1) Also identified by Revcode 0906
(2) Also identified by Revcodes 0912 and 0913
(3) Also identified by Revcode 0905

Appendix B-2
Idaho Department of Health and Welfare
Behavioral Health Cost Model Summary
Dual Population
Optum Encounters Incurred CY 2020, Paid through February 2021

Member Months:	79,169
Aggregate Completion Factor:	0.988

Service Description	HCPCS	Total Paid	Total Units	Utils/1,000	Unit Cost	Paid PMPM
Drug Tests	80305-80307	$1,428	194	29.4	$7.37	$0.02
Psychiatric Complex Interactive	90785	$2,446	978	148.3	$2.50	$0.03
Psychiatric Diagnositic Evaluation	90791, 90792	$77,472	1,151	174.5	$67.31	$0.98
Psychotherapy	90832-90834, 90836-90838	$859,113	21,280	3,225.6	$40.37	$10.85
Psychotheraypy for Crisis	90839, 90840	$3,467	152	23.0	$22.83	$0.04
Family Psychotherapy	90846, 90847	$76,620	1,352	204.9	$56.67	$0.97
Group Psychotherapy	90853	$9,471	684	103.7	$13.84	$0.12
Neurobehavioral Exam	96116, 96121	$22	2	0.3	$10.85	$0.00
Psychological Testing	96130-96133, 96136-96139, 96146	$9,518	453	68.7	$21.00	$0.12
Therapeutic Injection	96372	$1,464	164	24.9	$8.91	$0.02
Behavioral Modification Service	97151-97158, 0362T, 0373T	$0	14	2.1	$0.00	$0.00
Office Visit - New Patient	99201-99205	$6,351	109	16.6	$58.12	$0.08
Office Visit - Established Patient	99211-99215	$80,738	2,851	432.1	$28.32	$1.02
OTP Bundle	G2067, G2068, G2074	$0	-	-		$0.00
Other YES Services	G9007	$42	18	2.7	$2.31	$0.00
SUD Treatment Plan	H0001	$6,544	568	86.0	$11.53	$0.08
Drug/Alcohol Testing	H0003	$8,830	688	104.3	$12.84	$0.11
Individual Counseling	H0004	$35,379	2,940	445.7	$12.03	$0.45
Group Counseling	H0005	$87,564	13,794	2,090.8	$6.35	$1.11
Intensive OP Treatment	H0015 (1)	$2,023	16	2.5	$122.84	$0.03
Crisis Response	H0030	$1,337	46	7.0	$28.82	$0.02
CANS Assessment	H0031	$763	50	7.6	$15.15	$0.01
Individualized Skills Building Treatment Plan	H0032	$50,488	2,807	425.5	$17.99	$0.64
Partial Hospitalization	H0035 (2)	$18,214	50	7.6	$364.25	$0.23
Community Reintegration	H0036	$0	-	-		$0.00
Peer Support	H0038	$850,116	66,475	10,075.9	$12.79	$10.74
Family Support	H0046	$0	1	0.2	$0.00	$0.00
Functional Assessment Tool	H1011	$13,330	699	106.0	$19.06	$0.17
Crisis Intervention	H2011	$10,163	369	55.9	$27.56	$0.13
Behavioral Health Day Treatment	H2012	$0	-	-		$0.00
Individual Skills Training	H2014	$48,763	12,927	1,959.3	$3.77	$0.62
Psych Rehab Service	H2017	$676,023	53,207	8,064.8	$12.71	$8.54
Psychoeducational Services	H2027	$100	6	0.9	$16.64	$0.00
Intensive Home & Community Based Service	H2033	$0	-	-		$0.00
Unskilled Respite Care	S5150	$0	-	-		$0.00
Intensive OP Psych Service	S9480 (3)	$0	-	-		$0.00
Crisis Center Services	S9485	$73,929	264	40.0	$280.24	$0.93
Language Interpretation Services	T1013	$13,268	1,358	205.8	$9.77	$0.17
Telehealth Fee	T1014, Q3014	$77,061	4,443	673.5	$17.34	$0.97
Clinical Visit	T1015	$323,933	2,307	349.7	$140.41	$4.09
Targeted Case Management	T1017	$290,181	23,530	3,566.6	$12.33	$3.67
Transportation Reimbursement	T2002	$6,649	12,793	1,939.0	$0.52	$0.08
Not Mapped	Other	$4,513	2,415	366.0	$1.87	$0.06
Total Services For Capitation		**$3,727,322**	**231,157**	**35,037.4**	**$16.12**	**$47.08**
Community Reinvestment Services						
Community Transition Support	H2015	$0	-	-		$0.00
Total Services Included in Data		**$3,727,322**	**231,157**	**35,037.4**	**$16.12**	**$47.08**

(1) Also identified by Revcode 0906
(2) Also identified by Revcodes 0912 and 0913
(3) Also identified by Revcode 0905

Appendix B-3
Idaho Department of Health and Welfare
Behavioral Health Cost Model Summary
Expansion Population
Optum Encounters Incurred CY 2020, Paid through February 2021

Member Months: 936,248
Aggregate Completion Factor: 0.984

Service Description	HCPCS	Total Paid	Total Units	Utils/1,000	Unit Cost	Paid PMPM
Drug Tests	80305-80307	$274,042	12,019	154.1	$22.80	$0.29
Psychiatric Complex Interactive	90785	$17,478	4,567	58.5	$3.83	$0.02
Psychiatric Diagnositic Evaluation	90791, 90792	$1,239,580	15,629	200.3	$79.31	$1.32
Psychotherapy	90832-90834, 90836-90838	$6,602,782	130,577	1,673.6	$50.57	$7.05
Psychotheraypy for Crisis	90839, 90840	$48,755	629	8.1	$77.45	$0.05
Family Psychotherapy	90846, 90847	$368,941	5,123	65.7	$72.02	$0.39
Group Psychotherapy	90853	$96,059	6,676	85.6	$14.39	$0.10
Neurobehavioral Exam	96116, 96121	$2,660	60	0.8	$44.39	$0.00
Psychological Testing	96130-96133, 96136-96139, 96146	$202,898	5,485	70.3	$36.99	$0.22
Therapeutic Injection	96372	$10,223	620	7.9	$16.49	$0.01
Behavioral Modification Service	97151-97158, 0362T, 0373T	$14	43	0.6	$0.32	$0.00
Office Visit - New Patient	99201-99205	$261,477	2,276	29.2	$114.90	$0.28
Office Visit - Established Patient	99211-99215	$950,637	17,319	222.0	$54.89	$1.02
OTP Bundle	G2067, G2068, G2074	$0	4	0.1	$0.00	$0.00
Other YES Services	G9007	$404	19	0.2	$21.76	$0.00
SUD Treatment Plan	H0001	$302,928	25,315	324.5	$11.97	$0.32
Drug/Alcohol Testing	H0003	$263,668	21,130	270.8	$12.48	$0.28
Individual Counseling	H0004	$1,406,707	118,917	1,524.2	$11.83	$1.50
Group Counseling	H0005	$4,395,157	715,042	9,164.8	$6.15	$4.69
Intensive OP Treatment	H0015 (1)	$1,765,354	15,792	202.4	$111.78	$1.89
Crisis Response	H0030	$5,772	197	2.5	$29.35	$0.01
CANS Assessment	H0031	$7,437	398	5.1	$18.68	$0.01
Individualized Skills Building Treatment Plan	H0032	$147,954	8,612	110.4	$17.18	$0.16
Partial Hospitalization	H0035 (2)	$1,780,993	4,579	58.7	$388.94	$1.90
Community Reintegration	H0036	$0	28	0.4	$0.00	$0.00
Peer Support	H0038	$1,555,246	117,767	1,509.4	$13.21	$1.66
Family Support	H0046	$369	27	0.3	$13.63	$0.00
Functional Assessment Tool	H1011	$72,108	3,942	50.5	$18.29	$0.08
Crisis Intervention	H2011	$54,752	2,108	27.0	$25.97	$0.06
Behavioral Health Day Treatment	H2012	$0	-	-		$0.00
Individual Skills Training	H2014	$18,780	4,415	56.6	$4.25	$0.02
Psych Rehab Service	H2017	$889,774	67,809	869.1	$13.12	$0.95
Psychoeducational Services	H2027	$2,500	251	3.2	$9.96	$0.00
Intensive Home & Community Based Service	H2033	$0	-	-		$0.00
Unskilled Respite Care	S5150	$48	12	0.2	$3.89	$0.00
Intensive OP Psych Service	S9480 (3)	$21,401	666	8.5	$32.14	$0.02
Crisis Center Services	S9485	$1,374,417	4,323	55.4	$317.96	$1.47
Language Interpretation Services	T1013	$929,489	93,440	1,197.6	$9.95	$0.99
Telehealth Fee	T1014, Q3014	$1,340,525	71,873	921.2	$18.65	$1.43
Clinical Visit	T1015	$6,099,139	33,772	432.9	$180.60	$6.51
Targeted Case Management	T1017	$1,988,271	159,044	2,038.5	$12.50	$2.12
Transportation Reimbursement	T2002	$16,788	30,200	387.1	$0.56	$0.02
Not Mapped	Other	$1,447,231	57,386	735.5	$25.22	$1.55
Total Services For Capitation		**$35,962,757**	**1,758,093**	**22,533.7**	**$20.46**	**$38.41**
Community Reinvestment Services						
Community Transition Support	H2015	$0	3	0.0	$0.00	$0.00
Total Services Included in Data		**$35,962,757**	**1,758,096**	**22,533.7**	**$20.46**	**$38.41**

(1) Also identified by Revcode 0906
(2) Also identified by Revcodes 0912 and 0913
(3) Also identified by Revcode 0905

Attachment 3 - 2021113 SFY Dental Capitation Rate Certification

MILLIMAN REPORT

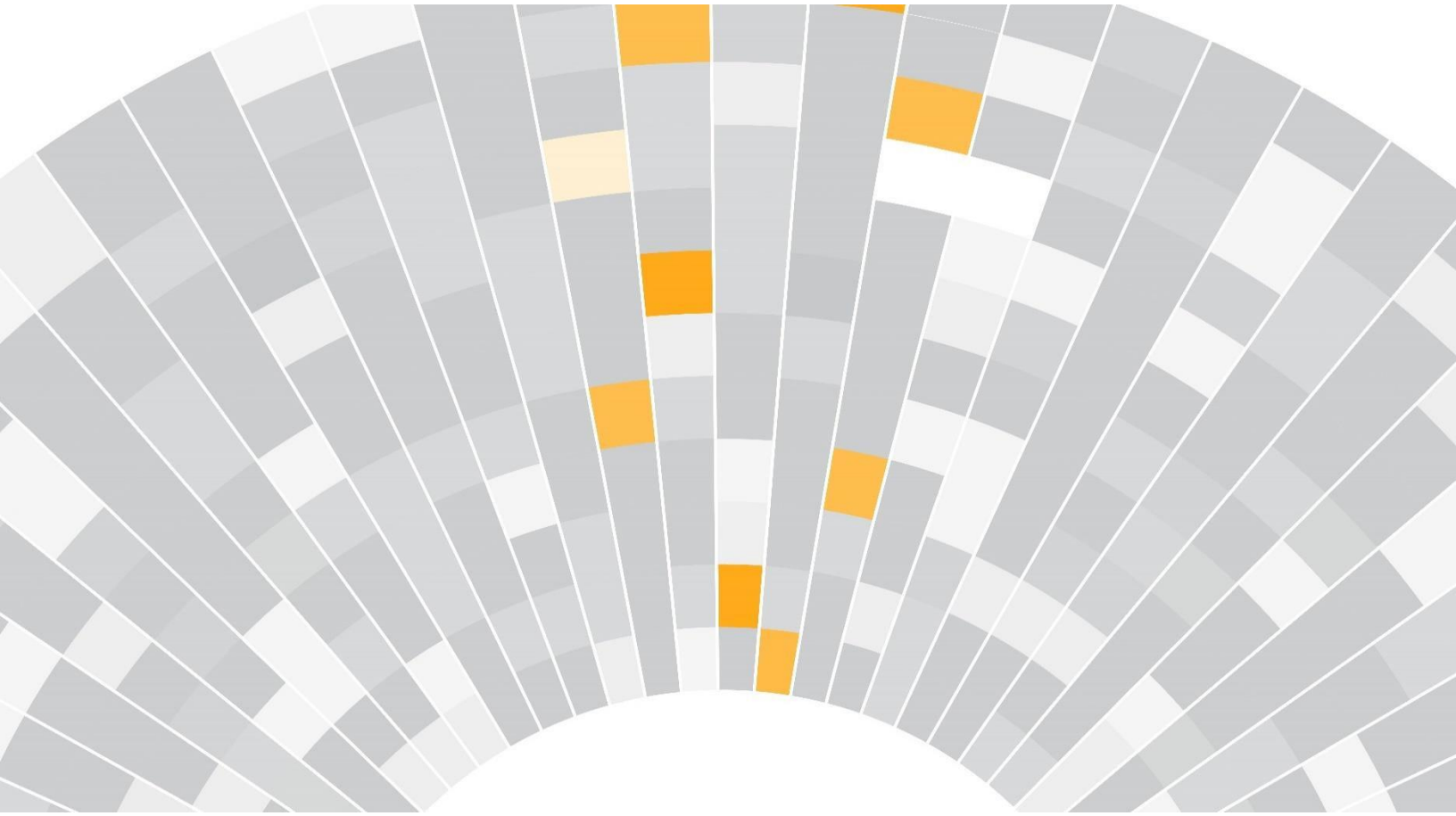
Idaho Medicaid Managed Care: SFY 2020 Dental Capitation Rate Development

Idaho Smiles

STATE OF IDAHO, DEPARTMENT OF HEALTH AND WELFARE

November 2020

Ben Diederich, FSA, MAAA
Jamie Rindfuss, ASA, MAAA



Milliman

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Executive Summary

INTRODUCTION

The Idaho Department of Health and Welfare (DHW) retained Milliman, Inc. (Milliman) to develop actuarially sound dental capitation rates. This report provides the supporting documentation for capitation rates which will be paid to the dental benefit administrator (DBA) during the state fiscal year (SFY) 2020 contract period (July 1, 2019 through June 30, 2020).

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2019-2020 Medicaid Managed Care Rate Development Guide (CMS Guide), published March 2019:

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
- The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

The prior rates were certified for the calendar year (CY) 2019 period. The first six months of the rates certified in this document overlap with the prior rating period and are intended to supersede them.

CMS Guide Index [Section I.1.B.ii]

We indexed each section of this report to the corresponding section of the "2019-2020 Medicaid Managed Care Rate Development Guide". Throughout this report, sub-headings (like the one above) are utilized to identify the items described within the CMS Guide in order to index each section within this report's table of contents. For example, the contents within the brackets above refer to Section I, subsection 1 "General Information", bullet B "Appropriate Documentation". This notation appears in the table of contents with page number references, as well as the body of this rate certification for easy navigation.

CAPITATION RATES

Table 1 illustrates composite dental capitation rates effective July 1, 2019 through June 30, 2020 by aid category. Composite values have been calculated utilizing our projected SFY 2020 membership distribution.

TABLE 1: PROPOSED SFY 2020 DENTAL CAPITATION RATES, GROSS OF WITHOLD

AID CATEGORY	PROJ SFY 2020 MM	CY 2019 RATE	SFY 2020 RATE	RATE CHANGE
Adults	878,448	$ 14.82	$ 16.86	13.8%
Children – Basic	1,898,044	16.72	19.01	13.7%
Children – Enhanced	310,219	18.35	20.86	13.7%
Composite (w/o Expansion)	**3,086,711**	**$ 16.34**	**$18.58**	**13.7%**
Expansion	406,140	N/A	$ 15.00	N/A
Composite (w Expansion)	**3,492,851**	**$ 16.34**	**$18.17**	**11.2%**

SUMMARY OF CHANGES

The following methodology changes were made for rate development effective during the SFY 2020 contract period relative to the CY 2019 rate development:

- We included an adjustment for the fee schedule change effective July 1, 2019.
- We have included capitation rates for the New Adult Group / VIII Group (Expansion) population for the first time, since they will receive coverage effective January 1, 2020. The base data used for these rates is the same as the adult rates, with additional factors for program ramp-up which are described later in this report.
- We applied factors to each rate cell to reflect expected MCNA cost management activities.

Tables 2a and 2b illustrate the stepwise impacts of the individual adjustments in the development of the SFY 2020 proposed capitation rates. Each row reflects the amount a key assumption contributes to the overall rate.

TABLE 2A: STEPWISE IMPACTS ON SFY 2020 RATES, GROSS OF WITHHOLD, PMPM

COMPONENT	ADULT	EXPANSION	CHILDREN - BASIC	CHILDREN - ENHANCED	COMPOSITE
Projected SFY 2020 MM	878,448	406,140	1,898,044	310,219	3,492,851
Base Data	$13.15	$13.15	$15.13	$16.24	$14.50
Trend	0.25	0.25	0.34	0.37	0.31
Fee Schedule Change	1.18	1.18	1.07	1.10	1.11
Expansion Ramp-Up	n/a	(1.60)	n/a	n/a	(0.19)
Management Factor	(0.25)	(0.23)	(0.38)	0.02	(0.29)
Administrative Load	2.53	2.25	2.85	3.13	2.73
Final Rate	**$16.86**	**$15.00**	**$19.01**	**$20.86**	**$18.17**

TABLE 2B: STEPWISE IMPACTS ON SFY 2020 RATES, GROSS OF WITHHOLD, %

COMPONENT	ADULT	EXPANSION	CHILDREN - BASIC	CHILDREN - ENHANCED	COMPOSITE
Projected SFY 2020 MM	878,448	406,140	1,898,044	310,219	3,492,851
Base Data	**78%**	**88%**	**80%**	**78%**	**80%**
Trend	1%	2%	2%	2%	2%
Fee Schedule Change	7%	8%	6%	5%	6%
Expansion Ramp-Up	n/a	(11%)	n/a	n/a	(1%)
Management Factor	(2%)	(2%)	(2%)	0%	(2%)
Administrative Load	15%	15%	15%	15%	15%
Composite	**100%**	**100%**	**100%**	**100%**	**100%**

FISCAL IMPACT

Table 3 illustrates estimated State and Federal expenditures by aid category for the twelve-month contract period from July 1, 2019 to June 30, 2020. We have projected SFY 2020 expenditures using SFY 2020 enrollment projections from DHW. State-only expenditures were estimated using the following estimated SFY 2020 FMAP rates, which are a blend of federal fiscal year (FFY) 2019[1] and FFY 2020[2] FMAP rates for TANF and Check-up populations, and CY 2020 for Expansion:

- Adult (Standard) – 70.54%
- Expansion – 90.00%[3]
- Child (Standard) – 70.54%
- CHIP – 93.06%

1 https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
2 https://www.federalregister.gov/documents/2018/11/28/2018-25944/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for
3 https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/

TABLE 3: SFY 2020 DENTAL RATES, GROSS OF WITHHOLD, FEDERAL VS. STATE EXPENDITURES ($ MILLIONS)

AID CATEGORY	PROJ SFY 2020 MM	SFY 2020 PROPOSED RATE PMPM	SFY 2020 TOTAL EXP. ($M)	SFY 2020 FMAP	SFY 2020 STATE EXP. ($M)	SFY 2020 FED EXP. ($M)
Adult	878,448	$ 16.86	$ 14.8	70.5%	$ 4.4	$ 10.4
Expansion	406,140	15.00	6.1	90.0%	0.6	5.5
Children - Basic	1,898,044	19.01	36.1	73.6%	9.5	26.5
Children - Enhanced	310,219	20.86	6.5	71.6%	1.8	4.6
Composite	**3,492,851**	**$18.17**	**$ 63.5**	**74.2%**	**$ 16.3**	**$ 47.1**

APPENDICES

Appendix A provides the SFY 2020 capitation rates by rate cell compared to the CY 2019 capitation rates. It also illustrates the steps applied to benefit cost projections subsequent to Appendix B to develop monthly capitation rates, including the application of administration/margin load, the 3% withhold , and the management adjustment.

Appendix B includes actuarial models by rate cell, which illustrate the development of each rate cell's SFY 2020 cost projection from base year experience and adjustments.

Appendix C includes responses to the CMS rate setting checklist.

Medicaid Managed Care Rates [Section I]

GENERAL INFORMATION [SECTION I.1]

General – Rate Development Standards [Section I.1.A]

Rating Period [Section I.1.A.i]:

This rate certification is for a 12-month rating period effective during SFY 2020.

Items included in an acceptable rate certification [Section I.1.A.ii]:

(a) A letter from the certifying actuary

This report concludes with a letter signed by the certifying actuary, Benjamin Diederich, who meets the requirements for an actuary in 42 CFR §438.2. The letter certifies that the final capitation rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.

(b) Final and certified capitation rates

Appendix A presents final and certified rates to be included in the DBA contract for all rate cells in accordance with 42 CFR §438.4(b)(4).

Table 1 illustrates a summary of proposed composite capitation rates compared to the prior period rates using projected SFY 2020 member months.

(c) Description of the program

(i) A summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

(A) The types and numbers of managed care plans included in the rate development:

Effective February 1, 2017, DHW is contracted with one DBA: Managed Care of North America (MCNA).

(B) A general description or list of the benefits that are required to be provided by the managed care plan or plans:

Idaho Medicaid covers dental services for adults and children as shown in Table 4 below. Pregnant women receive extra benefits through the Bright Beginnings Program.

TABLE 4: SFY 2020 MEDICAID COVERED DENTAL BENEFITS[4]

DESCRIPTION	CHILD COVERAGE	ADULT/EXPANSION COVERAGE
Routine Dental Exams	1 per 6 months	1 per year
Dental Cleanings	1 per 6 months	1 per 6 months
Fluoride	1 per 6 months	Not covered
Dental Sealants	Permanent molars; 1 per 36 months; ages 5-14	Not covered
Bitewing X-Rays	1 set per 6 months	1 set per 12 months
Full Mouth Series X-Rays or Equivalent	1 per 36 months	1 per 36 months
Fillings	1 per tooth per 24 months	1 per tooth per 24 months
Crowns	1 per tooth per 84 months	Not covered
Root Canals	1 per tooth per lifetime	Not covered
Root Planing and Scaling	1 per 24 months per quadrant	Not covered
Dentures	1 per 84 months	1 per 84 months
Extractions	1 per tooth per lifetime	1 per tooth per lifetime
Braces	Once per lifetime, if medically necessary	Not covered

4 http://docs.mcna.net/handbooks/mh-id-en, accessed March 14, 2020

Anesthesia	If approved, as medically necessary	If approved, as medically necessary
House, Hospital, Extended Facility Call	Not covered	1 per day
Behavior Management	Not covered	2 per year

(C) The areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

Managed care dental is provided through MCNA statewide. Idaho's dental benefit has been in managed care starting in SFY 2008, though not all populations transitioned to managed care at the same time.

(ii) Rating period:

The rating period covered by this rate certification is SFY 2020.

(iii) Covered populations:

The populations covered under the managed care program documented herein include:

- Section 1931 children
- Section 1931 adults
- Blind/disabled adults and children
- Aged beneficiaries
- Foster care children
- Title XXI State Children's Health Insurance Program (SCHIP)
- Medicare-Medicaid dual eligible adult participants who have chosen not to enroll in another managed care plan

(iv) Eligibility and enrollment criteria:

Enrollment in dental managed care is mandatory for all eligible populations.

(v) Special contract provisions under 42 CFR §438.6:

There are no new special contract provisions related to capitation rate development that were implemented into the DBA contract relative to the CY 2019 contract.

The DBA contract does not include any of the following special contract provisions:

- Incentive arrangements
- Risk sharing mechanisms beyond the minimum medical loss ratio
- State-directed payments
- Pass-through payments

(vi) Retroactive adjustments to capitation rates:

There are no retroactive adjustments applicable to the SFY 2020 capitation rates that are known at this time. The first six months of these rates represent a retroactive adjustment to the previously certified CY 2019 rates.

Differences among covered populations [Section I.1.A.iii]:

Any observed differences among covered populations are based on valid assumption differences driven by historical experience data or market research.

Cross-subsidization [Section I.1.A.iv]:

Capitation rates were developed such that payments from any rate cell do not cross-subsidize payments from any other rate cell.

Consistency of effective dates [Section I.1.A.v]:

The effective dates of changes to the Medicaid dental program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) are consistent with the assumptions used to develop the capitation rates. These changes have been presented in the Executive Summary, with detail included within the assumption documentation sections.

Minimum medical loss ratio [Section I.1.A.vi]:

Capitation rates have been developed in such a way that MCNA is expected to reasonably achieve a medical loss ratio (MLR) of at least 85% for the contract period, as calculated under 42 CFR §438.8.

The target pricing MLR is estimated to be 85% in aggregate prior to accounting for quality improvement and taxes and fees, and the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

The state will collect a remittance for the applicable years in which the vendor's MLR falls below 85%. More information is provided under Section I.4.C.ii.b of this rate report. This risk-sharing mechanism mitigates the risk to the state of claims being lower than expected, as experienced during the COVID-19 public health emergency.

Considerations for CMS approval [Section I.1.A.vii]:

As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:

(a) all adjustments are reasonable, appropriate, and attainable in the actuary's judgment.

All adjustments applied during the capitation rate development have been documented herein and are certified as part of the overall rates as reasonable, appropriate, and attainable by the certifying actuary.

(b) adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.

Additional adjustments to the capitation rates outside the rate setting process have not been made. If additional adjustments are made to the capitation rates prior to the end of the contract period, appropriate documentation will be submitted outlining any data, assumptions, methodology, and impact to the capitation rates.

(c) consistent with 42 CFR §438.7(c), the final contracted rates in each cell must either match the capitation rates in the rate certification. This is required in total and for each and every rate cell.

It is our understanding that the final contracted rates paid to MCNA for each rate cell will be consistent with the capitation rates included in Appendix A.

Certification period [Section I.1.A.viii]:

Rates are effective and certified for SFY 2020.

Procedures for rate certifications for rate and contract amendments [Section I.1.A.ix]:

(a) requirement for a new rate certification when rates change

If capitation rates change within SFY 2020 for reasons other than those outlined below in Section I.1.A.ix.(c), the state will submit a rate certification amendment outlining the data, assumptions, methodologies, and adjusted capitation rates as appropriate.

(b) supporting documentation for contract changes that revise covered populations or services under the contract

For contract amendments that do not affect rates, a new rate certification will not be developed. However, if a contract amendment revises covered populations or services under the contract, the certifying actuary will review the potential for a material capitation rate impact and provide an actuarial report documenting the data, assumptions, and methodologies used to evaluate the contract provisions.

(c) circumstances not requiring a new rate certification

(i) increase or decrease within 1.5% corridor

If capitation rates are adjusted within a 1.5% corridor of the base certification, the state's actuary will document rate changes within 1.5% of the originally certified rates through an actuarial memorandum.

(ii) application of risk scores under an approved methodology

The state's actuary will provide an actuarial report documenting the development of risk adjustment factors, including the data, assumptions, and methodologies used to develop the factors.

(d) contract amendment for rate changes other than already approved payment terms

The state will submit a contract amendment for any change that is made to the program other than what is defined within this report.

General – Appropriate Documentation [Section I.1.B]

Documentation detail required [Section I.1.B.i]:
States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:

(a) Data used

Table 5 identifies the types and sources of data and information utilized in developing the SFY 2020 dental capitation rates.

TABLE 5: BASE DATA SOURCES

EXPERIENCE TYPE	DATA SOURCE	EXPERIENCE DATES	DATE RECEIVED
Encounter Data	MCNA	7/1/2018 – 2/29/2020	3/6/2020
Detailed Monthly Eligibility	DHW	7/1/2018 – 2/29/2020	10/24/2019 & 3/12/2020
Enrollment Forecast	DHW	SFY 2020	7/20/2020
Covered Services	DHW	SFY 2020	11/4/2019
Fee Schedules	MCNA	SFY 2020	3/3/2020
Aid Category Definitions	DHW	SFY 2020	2/24/2020
Administrative Cost Summary	MCNA	CY 2019	3/2/2020
Financial Summaries	MCNA	CY 2019	3/3/2020
Contract Between DHW and MCNA	DHW	N/A	3/11/2020
SFY 2020 YTD MLR Calculation	MCNA	SFY 2020 (through June)	7/13/2020
Capitation Payment Detail Files	DHW	7/1/2018 – 9/30/2019	10/24/2019
Capitation Payment Control Totals	DHW	SFY 2019-2020	7/23/2020
Information Regarding Withhold Expectations	MCNA & DHW	7/1/2019-9/30/2019	3/3/2020 10/16/2020

Membership Data

The state's detailed monthly eligibility file was used as the membership basis for these rates. Because this file reflects a member's full eligibility record, not just eligibility for managed care, we only included records from the eligibility file that also had an associated capitation payment. This impact of this filtering to managed-care-eligible member months is shown in Table 7.

MCNA Experience

The base year experience used to develop the SFY 2020 capitation rates consists of services incurred during SFY 2019, paid through February 2020. This base period was selected because it was the most recent and complete 12 months of managed care data available.

We worked to reconcile the SFY 2019 claims loaded into our system to claim summaries reported in financial documents presented by MCNA. Note that these reconciliations were performed by incurred month, which was the level of detail at which we received summary information. Differences between the two sources were small enough that they could be reasonably expected to be due to accounting differences, such as in incomplete data estimates.

MCNA did not engage in sub-capitated arrangements for any dental services or provider groups. All encounters used in the base period were paid by MCNA on a fee-for-service basis.

Other Sources

In addition to historical dental experience, we reviewed and considered National Health Expenditures[5] (NHE) data to help inform our trend rate selection.

(b) Assumptions made:

Details supporting all assumptions are provided throughout this document. The following assumptions have been addressed during rate development:

- Dental service trends
- Fee schedule changes
- Expansion ramp-up
- Non-benefit expenses

(c) Methods for analyzing data and developing assumptions and adjustments:

Methodology applied in developing assumptions and adjustments are described throughout this document where assumptions are identified.

Rate certification index [Section I.1.B.ii]:

This report and its table of contents is the rate certification index.

Enhanced FMAP [Section I.1.B.iii]:

Populations eligible for enhanced FMAP under the DBA contract include the CHIP and Expansion (New Adult Group / VIII Group). Idaho's average effective FMAP rates for SFY 2020 by population are:

- Adult (Standard) – 70.54%
- Expansion – 90.00%[6]
- Child (Standard) – 70.54%
- CHIP – 93.06%

There are no services within the DBA contract that are eligible for enhanced FMAP.

Comparison to prior rating periods [Section I.1.B.iv]

(a) Comparison to previous certified rates

The prior contract period was CY 2019, with changes to capitation rates effective in SFY 2020.

Proposed capitation rates relative to prior capitation rates are illustrated in aggregate in Table 1 of the Executive Summary and Appendix A.

(b) Description of any material changes to the rates or rate development process not addressed elsewhere

Material changes include:

- We included an adjustment for a fee schedule change effective July 1, 2019.
- We have included capitation rates for the New Adult Group / VIII Group (Expansion) population for the first time, since they will receive coverage effective January 1, 2020. The base data used for these rates is the same as the adult rates, with additional factors for ramp-up which are described later in this report
- We applied factors to each rate cell to reflect expected MCNA cost management activities.

5 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
6 https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/

DATA [SECTION I.2]

Data – Rate Development Standards [Section 1.2.A]

Base data standards [Section I.2.A.i]:

(a) Validated data and audited financial reports

DHW and its vendors provided validated data for use in rate development. Section I.2.B discusses the provided data in more detail.

(b) Appropriate base data period

We reviewed historical data and selected a base period of July 1, 2018 to June 30, 2019, paid through February 28, 2020. We believe selection of this time period represents a credible base for projections, and it limits the development and application of adjustments that would be necessary if utilizing a longer time period.

(c) Appropriate base data population

The base data represents the same Medicaid population that will be enrolled in the program during the contract period.

(d) Alternative data sources

Not applicable.

Data – Appropriate Documentation [Section I.2.B]

Base data under 42 CFR §438.7(b)(1) [Section I.2.B.i]:

(a) A description of base data requested by the actuary

(i) A summary of the base data that was requested by the actuary.

Data requests were sent to DHW and MCNA. The items requested include:

- Detailed capitation membership and dental claims data from July 2017 – July 2019
- Control totals/financial reports
- Historical G&A Expenses
- Copy of the most current benefit manual available
- Copy of the most recent fee schedule
- Information regarding the withhold amount and expected return
- Clarification on how Expansion will be incorporated into the rate cell structure
- Anticipated experience for Expansion, and potential risk mitigation provisions
- Benefit changes and fee schedule changes between the base period and projection period
- Information on identifying FQHC encounters in the base data

Data was provided in full to the best of the state's and MCNA's abilities.

(ii) A summary of the base data that was provided by the state.

We received data directly from the state; however, it did not appear reasonable in aggregate. We are working with the state to reconcile its data to that provided by MCNA.

(iii) An explanation of why any base data requested was not provided by the state.

While the state does receive encounter data directly from MCNA, there were concerns with the ability to reconcile the data within the timeframe necessary for rate development. We are working with the state currently to reconcile their data for future use.

Description of data used to develop rates [Section I.2.B.ii]:

(a) Description of the data

(i) types of data used

We utilized managed care encounters, health plan financial statements, and state eligibility data in the development of capitation rates. Table 5 identifies additional details related to all data received.

(ii) age or time periods of all data used.

SFY 2019 eligibility and claims data served as the base data underlying the capitation rates presented herein.

(iii) sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).

Table 5 identifies the source of each individual data component utilized during rate development. All data was received from DHW or MCNA.

(iv) data used for subcapitated arrangements

All base claims data were provided by MCNA, which does not have subcapitation arrangements with any providers during either the base or rating period.

(b) Data quality and validation:

(i) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:

(A) completeness of the data.

(B) accuracy of the data.

(C) consistency of the data across data sources.

Per MCNA's contract with DHW, MCNA is required to certify encounter data, payment data, and all other information submitted to the state. Data is required to comply with the applicable certification requirements for data and documents specified by DHW pursuant to 42 C.F.R. § 438.604, 438.606 and 457.950(a)(2). MCNA provided the following information that we used in validating the data sources:

- Control totals for reconciliation:
  - Claim lag triangles
  - Member month control totals
- A reconciliation of control totals to the company financial statements
- An attestation of accuracy by a company officer

We have a series of internal data validation processes which were conducted upon receipt of each set of data from DHW and MCNA. We use reconciliation workbooks to fully reconcile costs and member month counts with the control totals from separate reports. We also perform reasonableness checks throughout the rate development as we review data and information at various levels to develop assumptions such as trend and completion factors. We maintain a collaborative relationship with the state and its contractors, such that we are able to discuss data review questions and concerns throughout the rate development process.

(ii) a summary of the actuary's assessment of the data.

As the certifying actuary, I have assessed the quality of available data to be sufficient for the purpose of developing projected costs for capitation rates effective during the SFY 2020 contract period. All data were reviewed at several professional levels by consultants, actuaries, and data analysts who have significant experience with Medicaid data. We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent.

(iii) any other concerns that the actuary has over the availability or quality of the data.

We do not have concerns about the availability or quality of the data used for our analysis.

(c) description of how the actuary determined what data was appropriate to use for the rating period:

(i) why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered

We utilized MCNA's encounter data as base experience data, which is the most representative source of future experience under the program as it is based on the population to be covered and services to be provided under the DBA contract in SFY 2020.

(ii) why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data

Not applicable.

(d) Reliance on a data book:

We did not rely on a data book.

Description of data adjustments [Section I.2.B.iii]:

(a) Credibility:

Each rate cell has enough membership in the base period to be considered fully credible without additional adjustment.

(a) Completion factors:

Because eight months had elapsed between the most recent month of data and when rates are developed, all data were considered complete and the completion impact was 0%. This assumption was corroborated by our review of historical claims runout patterns.

(b) Data errors:

We did not identify any errors in the data. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

(c) Program changes:

Fee schedule increase

Effective July 1, 2019, MCNA increased the fees for certain Certified Dental Technicians (CDT) codes for both children and adults. To account for this fee schedule increase, we applied the percentage increase to our base data at the CDT-level. The impact of this fee schedule increase is shown in Table 6 below.

TABLE 6: IMPACT OF FEE SCHEDULE CHANGE

CATEGORY OF SERVICE	ADULT	EXPANSION	CHILDREN - BASIC	CHILDREN - ENHANCED	COMPOSITE
Class I	0.0%	0.0%	0.0%	0.0%	0.0%
Class II	27.9%	27.9%	21.0%	19.5%	23.4%
Class III	9.6%	9.6%	14.9%	14.9%	13.0%
Class IV	0.0%	0.0%	0.0%	0.0%	0.0%
Unclassified	0.2%	0.2%	3.9%	3.1%	2.5%
Composite	**8.9%**	**8.9%**	**7.0%**	**6.7%**	**7.7%**

Management factors

Management factors represent cost management relative to the SFY 2019 base period expected by MCNA. The factors shown in Table 7 below were estimated based on discussions with MCNA and the state about cost savings and management opportunities which are expected to focus on the adult, Expansion, and child-basic rate cells. MCNA's management include:

- Provider contracting
- Utilization management
- Member and provider outreach.

TABLE 7: MANAGEMENT FACTORS

AID CATEGORY	MANAGEMENT ADJ.
Adult	0.98
Expansion	0.98
Children - Basic	0.98

Children - Enhanced	1.00
Composite	**0.98**

(d) Exclusions:

The members eligible for this dental program were all managed-care-eligible Medicaid beneficiaries in Idaho except those identified in the detailed eligibility file as "Medicare only."

Only services that will be covered under the managed care contract were included in our analysis. Claims were excluded if they did not have a record in the eligibility file, or if they were flagged as non-covered based on the age of the recipient at the time of service. These exclusions are shown in Table 8 below.

TABLE 8: RAW DATA EXCLUSIONS

COMPONENT	MEMBERSHIP	CLAIMS
Raw Total	3,616,167	$ 48,853,920
No Associated Capitated Payment	332,149	377,050
Medicare Only	72	20,616
Non-Covered Service		130,335
Final Base Data	**3,283,946**	**$ 48,325,919**

PROJECTED BENEFIT COSTS AND TRENDS [SECTION I.3]

Projected Benefit Cost – Rate Development Standards [Section I.3.A]

Allowed services [Section I.3.A.i]:

Final capitation rates are based only upon State Plan services as defined in the DBA contract and based on 42 CFR §438.3(c)(1)(ii) and 438.3(e). Included services represent provider payment rates that have been assessed to adequately allow an efficient DBA to deliver services for Medicaid-eligible enrollees in compliance with contractual requirements.

MCNA does not cover any value-added benefits.

Assumption variation [Section I.3.A.ii]:

Variations in the assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations. Additional documentation for adjustment development is included in Section I.3.B.

Development of benefit cost trends [Section I.3.A.iii]:

Selected trend rates have been developed in accordance with 42 CFR §438.5(d) and generally accepted actuarial principles and practices. We have assessed them to be reasonable for the Medicaid program covered by this certification. We relied on information from similar Medicaid managed care programs, National Health Expenditures data, and the Milliman *Health Cost Guidelines - Dental* (Dental HCGs).

Additional documentation for trend rates is included in Section I.3.B.iii.

In-lieu-of services under 42 CFR §438.3(e)(2) [Section I.3.A.iv]:

The DBA contract does not include provision for services in-lieu of State Plan services.

IMD treatment as in-lieu-of service [Section I.3.A.v]:

Services provided at Institutions for Mental Disease (IMDs) are not covered under this contract.

Projected Benefit Cost – Appropriate Documentation [Section I.3.B]

Final projected benefit cost [Section I.3.B.i]:

Appendices A and B contain final projected benefit costs for the SFY 2020 contract period.

Development of projected benefit costs [Section I.3.B.ii]:

Section I.1.B.i.(a) includes a description of data used. Assumptions and methodologies are documented below, and elsewhere in this report in the applicable section.

(a) a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.

The data used to develop dental projected benefit costs was managed care data—submitted by MCNA—from July 1, 2018 to June 30, 2019, paid through February 28, 2020. This data was grouped according to dental class, and rate cell. The data was summarized by utilization, unit cost and PMPM amounts. Encounters incurred at federally qualified health centers (FQHCs) were identified with the procedure code D9999 and grouped separately in cost models. The entire prospective payment system (PPS) rate paid to FQHCs is the responsibility of MCNA and is reflected in base data encounters.

Additionally, we relied on the Milliman *Health Cost Guidelines - Dental* (Dental HCGs) in conjunction with NHE data and projections to select trend assumptions. The Dental HCGs represent a conglomeration of data, research and actuarial judgement, and provide a flexible but consistent basis for projections for a wide variety of dental benefit plans. Included in the Dental HCGs are a range of trend factors for dental utilization, as well as considerations for how to select point estimates from these ranges based on an array of circumstances.

Though the Dental HCGs are developed for commercial dental rating structures, in the absence of more applicable Idaho Medicaid data, we assumed that similar secular trends would impact commercial and Medicaid markets. Given the large fee schedule increase in SFY 2020, and the vendor change in 2017, historical Idaho dental trends would not be a reliable predictor of future trend.

(b) any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.

Material changes are listed in the Executive Summary and throughout this report.

(c) the amount of overpayments to providers and a description of how the state accounted for this in rate development. See §438.608(d).

MCNA did not report any overpayments to providers outside of adjustments captured in their detailed encounter data.

Projected benefit cost trends [Section I.3.B.iii]:

(a) In accordance with 42 CFR §438.7(b)(2), this section must include:

(i) Data and assumptions used to develop trends:

(A) Descriptions of data and assumptions.

Given the large fee schedule increase in SFY 2020, and the vendor change in 2017, historical Idaho dental trends would not be a reliable predictor of future trend. The discontinuities between the data from different delivery systems would be pronounced enough that a multi-year regression study is not appropriate for trend development.

Rather, we relied on the Milliman Dental HCGs in conjunction with NHE trend projections to select trend assumptions.

(B) Reliance on experience

As described above, we did not rely on historical experience for trend assumption development due to transitions in recent years.

(ii) Methodologies used to develop trends:

Trends were selected based on judgement, and comparison to external sources. The midpoint of the Milliman Dental HCG composite trend was comparable to the NHE composite trend, so these sources are consistent on a total PMPM basis. The trends for class IV and unclassified services were based on the midpoint of the composite trend from the Milliman Dental HCGs. For rating, we selected the Milliman Dental HCG utilization trend component. We decided not to apply the HCG charge trends because of the large fee schedule increase.

Table 9 shows the total impact of trend.

TABLE 9: COMPOSITE ANNUAL TRENDS

CATEGORY OF SERVICE	ADULT	EXPANSION	CHILDREN - BASIC	CHILDREN - ENHANCED	COMPOSITE
Class I	3.0%	3.0%	3.0%	3.0%	3.0%
Class II	1.5%	1.5%	1.5%	1.5%	1.5%
Class III	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%
Class IV	2.5%	2.5%	2.5%	2.5%	2.5%
Unclassified	2.5%	2.5%	2.5%	2.5%	2.5%
Composite	**1.9%**	**1.9%**	**2.2%**	**2.3%**	**2.1%**

(iii) Comparisons to historical trends:

Given the large fee schedule increase in SFY 2020, and the vendor change in 2017, historical Idaho dental trends would not be a reliable predictor of future trend. The discontinuities between the data from different delivery systems would be pronounced enough that a multi-year regression study is not appropriate.

(iv) documentation supporting the chosen trend rates and explanation of outlier and negative trends.

There was a lack of appropriate historical data for developing trends. As a result, national trends from Milliman's Dental HCGs were selected after confirming the levels were consistent with those seen in NHE data.

(b) Components of trend:

The trends are only applied to utilization. Because of the large fee schedule increase, charge trends were considered unnecessary.

(c) Variations in trend:

Selected trends vary by dental service class: I, II, III, IV and unclassified.

These variations in trend were not due to differences in federal financial participation.

(d) Other material adjustments to trend:

There are no other material adjustments to trend.

(e) Other non-material adjustments to trend:

There were no non-material adjustments made to trend.

Adjustments due to MHPAEA [Section I.3.B.iv]:

Not applicable.

In-lieu-of services [Section I.3.B.v]:

There were no services provided in lieu of State Plan services under the DBA contract during the experience period.

Retrospective eligibility periods [Section I.3.B.vi]:

(a) MCOs' responsibility to pay for claims incurred during the retroactive eligibility period

Retrospective eligibility periods covering services incurred prior to a member's application submission and approval are covered under the FFS delivery system.

(b) How claims information are included in the base data

Claims for retrospective eligibility periods prior to approval of a Medicaid application are not included in our base experience.

(c) How enrollment or exposure information is included in the base data

Exposure months for retrospective eligibility periods prior to approval of a Medicaid application are not included in our base experience.

(d) How capitation rates are adjusted to reflect retroactive eligibility period

Capitation rates are not explicitly adjusted to reflect retroactive eligibility periods because the treatment of retroactive eligibility periods is not changing between the base period and the projection period.

Impact of changes to covered benefits or services [Section I.3.B.vii]:

(a) more or fewer State Plan benefits covered by Medicaid managed care

Not applicable.

(b) recoveries of overpayments made to providers by health plans

MCNA did not report provider overpayments that were not included in their detailed claims data.

(c) requirements related to payments from health plans to any providers or class of providers

Not applicable.

(d) requirements or conditions of any applicable waivers

The DBA contract is operated under the authority of a 1915(b) Waiver, with approval to require enrollees to obtain medical care through the DBA. Sections 1902(a)(23) (freedom of choice) and 1902(a)(4) (mandating enrollment in a single PAHP) of the Social Security Act have all been waived. SFY 2020 capitation rates were developed in accordance with the terms of the Waiver.

(e) requirements or conditions of any litigation to which the state is subjected

Not applicable.

Impact of non-material changes to covered benefits or services [Section I.3.B.viii]:

(a) aggregate adjustment for changes determined by the actuary to be non-material

(i) list of all non-material adjustments used in the rate development process

All adjustments used in developing projected benefit costs have been described elsewhere in this report. We have not aggregated multiple changes together in the development of adjustment factors.

(ii) description of why changes were considered non-material and how they were aggregated

Not applicable.

(iii) description of where in the rate-setting process adjustments were applied

Not applicable.

(iv) aggregate cost impact of non-material adjustments

Not applicable.

SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT [SECTION I.4]

Incentive Arrangements [Section I.4.A]

Incentive Arrangements – Rate Development Standards [Section I.4.A.i]

(a) description of incentives included in the contract between the state and the health plans

The DBA contract does not include any incentive arrangements for additional funds over and above the capitation rates tied to meeting performance targets.

(i) incentive payment amounts

There are no incentives included in the DBA contract

Incentive Arrangements – Appropriate Documentation [Section I.4.A.ii]

(a) description of incentive arrangements

(ii) time period of arrangement

Not applicable

(iii) enrollees, services, and providers covered

Not applicable

(iv) purpose

Not applicable

(v) confirmation that incentive payments will not exceed 105% of capitation payments

Not applicable

(vi) description of any effect on capitation rates

Not applicable

Withhold Arrangements [Section I.4.B]

Withhold Arrangements – Rate Development Standards [Section I.4.B.i]

(a) description of withhold arrangement

An initial quality withhold of 3% will be withheld from the capitation rates for all participants for SFY 2020. Note that the withhold payment period is based on the calendar year (CY).

The withhold will be released to the vendor upon demonstration of satisfactory performance with respect to preventive services, as shown by either maintaining or increasing the performance for the National Quality Forum measure 1334. The vendor must provide the report for the first quarter of the contract 180 days after the commencement of the contract and the State of Idaho will pay within 90 days after the report is received. Per the contract, reports and payments will continue on the same schedule for the term of the contract, and if the vendor fails to meet the withhold performance indicator in a specific quarter, the withhold will not be paid.

The earned withhold for the CY 2019 and CY 2020 contract periods have not yet been calculated. MCNA earned back the withhold in full for the CY 2017 and CY 2018 contract periods.

(i) targets distinct from general operational requirements

MCNA must demonstrate quality performance by maintaining or increasing the percentage of children under age 21, receiving preventive services under codes D1000-D1999 as stated in the CMS/EPSDT 416 report. In addition to maintaining or increasing the preventative service codes for children, MCNA must also maintain or increase the percentage for adults, 21 and older, for the same service codes.

(ii) withhold penalty for noncompliance of operational requirements

There is no penalty withheld from capitation premium for noncompliance of operational requirements.

(b) actuarial soundness of capitation payment(s) minus any withhold that is not reasonably achievable

The withhold for CY 2020 is not reasonably achievable because of the impact of COVID-19 on utilization. Note that we consider these rates actuarially sound both net and gross of withhold, because the withhold is funded in the rates through the assumption for risk margin.

Withhold Arrangements – Appropriate Documentation [Section I.4.B.ii]

(iii) the time period and the purpose of the arrangement

The withhold is reviewed on a quarterly basis and payments are made on a calendar year cycle. The rates certified in this report relate to the withhold payments made with data that overlaps with CY 2019 (six months of these rates) and CY 2020 (six months of these rates).

The purpose of the arrangement is to provide financial incentive for MCNA to achieve specific utilization levels in order to meet the priorities, goals, and areas of clinical focus identified in Idaho's quality strategy.

(iv) description of the total percentage of the certified capitation rates being withheld through withhold arrangements.

The total percentage withheld from the total capitation rate is 3%.

(v) estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination

We have assessed that the withhold is not reasonably achievable for CY 2020 due to utilization dampening during the COVID-19 pandemic.

(vi) a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.

We reviewed MCNA's historical risk-based capital ratios at a corporate level (NAIC #14063), which have been sufficiently above the 200% company action level in prior years as reported in their NAIC statutory annual statements. Based on this information, we expect that MCNA will be able to continue operations with no additional cash flow for CYs 2019 and 2020.

(vii) a description of any effect that the withhold arrangements have on the development of the capitation rates.

The withhold arrangement did not have any impact on the development of the capitation rates.

Risk-Sharing Mechanisms [Section I.4.C]

Risk Mitigation – Rate Development Standards [Section I.4.C.i]

(a) Risk-sharing mechanisms in the MCO contracts

The DBA contract does not contain any risk mitigation arrangements outside of the minimum MLR provision outlined in 42 CFR §438.8.

(b) Potential affect to final net payments to the MCOs

Not applicable.

Risk Mitigation – Appropriate Documentation [Section I.4.C.ii]

(a) Description of risk-sharing mechanisms other than minimum MLR or reinsurance

Not applicable.

(b) MLR risk-sharing arrangement:

MCNA is subject to a settlement after each state fiscal year depending on its medical loss ratio (MLR). The MLR is calculated and reported consistently with 42 CFR 438.8(c).

If the MLR is lower than 85%, then MCNA shall remit 100% of the difference in total applicable revenue to achieve an 85% MLR. This risk-sharing mechanism mitigates the risk to the state of claims being lower than expected, as experienced during the COVID-19 public health emergency.

(c) Reinsurance requirements.

There are no reinsurance requirements in place.

Delivery System and Provider Payment Initiatives [Section I.4.D]

State-Directed Payments – Rate Development Standards [Section I.4.D.i]

(a) state-directed delivery system and provider payment initiatives under 42 CFR §438.6(c)

(i) value-based purchasing models for provider reimbursement - pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services

The state has not implemented any value-based purchasing models under the DBA contract effective in SFY 2020.

(ii) multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives

The state has not implemented any Medicaid-specific delivery system reforms or performance improvement initiatives linked to a directed payment effective in SFY 2020.

(iii) minimum fee schedule for network providers providing a particular contract service

The state is not requiring any minimum fee schedules under the DBA contract effective in SFY 2020.

(iv) uniform dollar or percentage increase for network providers that provide a particular service under the contract.

The state is not requiring any uniform dollar or percentage increases for provider reimbursement under the DBA contract effective in SFY 2020.

(v) maximum fee schedule for network providers providing a particular contract service, allowing health plans to retain ability to reasonably manage risk

The state is not requiring a maximum fee schedule under the DBA contract effective in SFY 2020.

(b) how each approved state-directed payment is reflected in the payments to the managed care plan from the state

Not applicable.

(i) documentation related to the payment term in the initial, base rate certification

Not applicable.

(ii) material directed payments addressed through separate payment terms

Not applicable.

(iii) subsequent documentation of directed payments made

Not applicable.

(iv) capitation rate amendment

Not applicable.

State-Directed Payments – Appropriate Documentation [Section I.4.D.ii]

(a) description of any delivery system and provider payment initiatives

(i) a brief description of the delivery system and provider payment initiative(s) included in the rates for this rating period

Not applicable.

(ii) state-directed payments incorporated into the base capitation rates as a rate adjustment

Not applicable.

(iii) state-directed payments with separate payment terms (made outside capitation rates)

Not applicable.

Pass-Through Payments [Section I.4.E]

Not applicable.

PROJECTED NON-BENEFIT COSTS [SECTION I.5]

Non-Benefit Cost – Rate Development Standards [Section I.5.A]

See section I.5.B.

Non-Benefit Cost – Appropriate Documentation [Section I.5.B]

Description of non-benefit cost projection [Section I.5.B.i]:

MCNA's contract with the state specifies that the administrative load cannot exceed 15% of premium. We have assumed a non-benefit expense load of 15% of revenue for the SFY 2020 rates. This is the same assumption as was used in the CY 2019 rates. The SFY 2020 load of 15% reflects historical administrative expenses reported by MCNA and a provision for 4% of risk margin.

We have compared this administrative load to actual administrative costs as filed by MCNA, as well as loads added to capitation rates in other state Medicaid programs. These comparisons indicate that the 15% load is reasonable.

There is no load for state premium tax. The Idaho Department of Insurance has applied a 4 cent PMPM tax on this program, which we consider included in the 15% of premium retention load.

Consistent with prior years, should the withhold amounts be distributed, the non-benefit expense load will be 15% of revenue. Should the withhold amounts not be distributed to MCNA, the non-benefit expense load will be reduced by 3%. The withhold reduction lowers the profit margin assumption component of the non-benefit expense.

Categories of non-benefit costs [Section I.5.B.ii]:

Table 10 illustrates the projected non-benefit costs by category of costs.

TABLE 10: NON-BENEFIT COSTS AS A % OF PREMIUM

COMPONENT	CY 2018 ACTUAL	CY 2019 ACTUAL	SFY 2020 RATES
Administrative Costs	10.2%	9.4%	11.0%

Contribution to surplus/risk margin			4.0%
Sum of components			15.0%

Health Insurance Providers Fee [Section I.5.B.iii]:

(a) how the fee is incorporated into capitation rates

The Health Insurance Providers Fee (HIPF) is not included in the capitation rates presented with this report. For the 2020 HIPF payment year, capitation rates that apply to CY 2019 will be adjusted retroactively to account for the HIPF. Capitation rates that apply to the CY 2020 year will not be adjusted.

(b) if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification

Not applicable.

(c) description of how the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known

Not applicable.

(d) if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee

Revised capitation rates will be calculated when MCNA's HIPF information becomes available. We expect to use the following method to develop and apply the HIPF adjustment:

- MCNA will provide its final notice of the fee amount as reported by the United States Internal Revenue Service (IRS).
- We will review MCNA's allocation of the final notice fee amount to the Idaho Medicaid programs.
- We will use MCNA's nationwide premiums and Idaho Medicaid premiums as well as the total HIPF reported by the IRS to estimate the impact of the HIPF on the first half of Idaho Medicaid SFY 2020 capitation rates. We will then include provision for applicable state and federal income taxes..
- A required rate increase will be calculated by comparing the resulting HIPF reimbursement to applicable capitation paid in SFY 2020 (between July 1, 2019 and December 31, 2019). The calculated increase due to HIPF will be applied to the applicable SFY 2020 capitation rates.

(e) if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix) (e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed

Not applicable.

(f) for managed care plans that were required to pay the fee in 2014, 2015, 2016, and/or 2018, a description as to whether or not the fee has been included in the capitation rates for those years (either prospectively in the rates or through amendments to the initially certified rates)

MCNA was required to pay the fee in 2018, and prior to that did not operate in Idaho. The HIF has never been included in prospective capitation rates for Idaho dental.

RISK ADJUSTMENT AND ACUITY ADJUSTMENTS [SECTION I.6]

Rate Development Standards [Section I.6.A]

These rates do not contain risk adjustment or acuity adjustment factors.

Appropriate Documentation [Section I.6.B]

Not applicable.

Medicaid Managed Care Rates with Long-Term Services and Supports [Section II]

Not applicable.

New Adult Group Capitation Rates [Section III]

DATA [SECTION III.1]

Description of data used [Section III.1.A]:

See sections I.1.B.i.(a) and I.2.B.iii. The base data used for Expansion rates was the same as for the legacy adult population.

Prior Expansion rates [Section III.1.B]:

Not applicable; these are the first Expansion rates for this program.

PROJECTED BENEFIT COSTS [SECTION III.2]

Summary of assumptions [Section III.2.A]:

(a) Data used:

See section I.1.B.i.(a).

(b) Changes in data sources:

The following data sources were used to review the Expansion rates:

- High-level anecdotal information from other states that have previously expanded
- Emerging MCNA experience from January and February 2020

Based on our review of these data, we did not see a consistent pattern of differences in acuity between Expansion adults and legacy Medicaid adults in a stable market.

(c) Changes to assumptions:

(i) Acuity or health status adjustments

There are no acuity or health status adjustments that apply specifically to the Expansion rates.

(ii) Pent-up demand:

Our evaluation of pent-up demand included a high-level and anecdotal review of experience from other states and a review of emerging experience for Idaho dental in January and February 2020

This review indicated that an adjustment for program ramp-up was appropriate. The ramp-up adjustment is intended to reflect the following:

- Medicaid members newly enrolled in the program will take time to become familiar with their benefits.
- Dental may be a lower priority service for most newly enrolled Medicaid members, relative to primary care or other major medical services.
- Providers who accept Medicaid dental patients may not be able to accept patients quickly.

These factors, shown in Table 11, were applied by class of service to legacy adult data to project the level of ramp-up expected in Expansion. The assumption for FQHC encounters (D9999 service code) was based on the underlying distribution of services within those encounters. The assumptions are based on judgement and the fact that class I services tend to be utilized first, as a gateway to more complex services. Therefore, the ramp-up assumption for class I services is assumed to be less than the ramp-up for class II and III services.

TABLE 11: PROGRAM RAMP-UP FACTORS

CATEGORY OF SERVICE	FACTOR
Class I	0.950
Class II	0.855
Class III	0.855

Class IV	1.000
Unclassified	0.912
Composite	0.884

(iii) Adverse selection:

We did not make an explicit adjustment for adverse selection due to limited data available. We expect that the lack of member cost sharing would reduce the potential for adverse selection. It is our implicit assumption that the factor described above includes provision for adverse selection.

(iv) Demographics:

There are no demographic adjustments that apply specifically to the Expansion rates.

(v) Delivery system differences:

There are no delivery system adjustments that apply specifically to the Expansion rates.

(vi) Other:

There are no other adjustments that apply specifically to the Expansion rates.

Key assumptions to include [Section III.2.B]:

See section II.2.A

Benefit plan changes [Section III.2.C]:

There are no changes to the benefit plan that apply specifically to the Expansion rates.

Other material changes [Section III.2.D]:

There are no other material changes that apply specifically to the Expansion rates.

PROJECTED NON-BENEFIT COSTS [SECTION III.3]

New adult non-benefit costs [Section III.3.A]

See section I.5

Comparison to other populations [Section III.3.B]:

See section I.5

FINAL CERTIFIED RATES [SECTION III.4]

Comparison to prior rates [Section III.4.A.i]:

See Appendix A.

Description of other material changes [Section III.4.A.ii]:

All material changes are described elsewhere in this report.

RISK MITIGATION STRATEGIES [SECTION III.5]

Description of risk mitigation strategy [Section III.5.A]:

Not applicable

Additional risk mitigation information [Section III.5.B]:

There are no additional risk mitigation strategies specific to the Expansion population in the SFY 2020 rates.

Data Reliance and Caveats

We have modeled total costs in a managed care environment based on prior managed care data. The managed care assumptions implicit in these rates may not be realized.

This analysis is intended for the use of the State of Idaho (DHW) in support of the Medicaid managed care dental programs. No portion may be relied upon by any other party without Milliman's prior written consent. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for DHW by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of the DBA to make an independent determination as to the adequacy of the proposed capitation rates for their organization.

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis.

This analysis has relied extensively on data provided by DHW and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

The terms of Milliman's contract with the Idaho Department of Health and Welfare, effective July 1, 2019, apply to this report and its use.

Actuarial Certification

I, Benjamin Diederich, am a consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Idaho Department of Health and Welfare (DHW) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for the state's managed care program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the twelve-month period of state fiscal year (SFY) 2020.

To the best of my information, knowledge and belief, for the SFY 2020 period, the capitation rates offered by DHW are actuarially sound and comply with the requirements of 42 CFR § 438.4 and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the State of Idaho and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

The capitation rates developed herein may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DHW. The health plan may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

11/13/2020

Benjamin Diederich, FSA, MAAA
Consulting Actuary

Date

APPENDIX A

Appendix A
State of Idaho
Department of Health and Welfare
SFY 2020 Dental Rate Development
DBA-submitted claims data incurred July 2018 to June 2019; paid through February 2020

Rate Cell	CY 2019 Experience MMs	SFY 2020 Projected MMs	Projected Benefit Cost PMPM Pre-COVID Adj (1)	Management Adjustment	Adjusted Benefit Cost PMPM	Administrative Cost	Gross of Withhold SFY 2020 Rate PMPM	Net of Withhold SFY 2020 Rate PMPM	Net of Withhold CY 2019 Rate	Rate Change
Adult	872,518	878,448	$ 14.58	0.98	$ 14.33	$ 2.53	$ 16.86	$ 16.35	$ 14.38	13.8%
Children - Basic	2,074,901	1,898,044	16.53	0.98	16.16	2.85	19.01	18.44	16.21	13.7%
Children - Enhanced	336,527	310,219	17.71	1.00	17.73	3.13	20.86	20.23	17.80	13.7%
Composite (w/o Expansion)	3,283,946	3,086,711	$ 16.09		$ 15.80	$ 2.79	$ 18.58	$ 18.03	$ 15.85	13.7%
Expansion	0	406,140	$ 12.98	0.98	$ 12.75	$ 2.25	$ 15.00	$ 14.55	N/A	N/A
Composite (w Expansion)	3,283,946	3,492,851	$ 15.73	0.98	$ 15.44	$ 2.73	$ 18.17	$ 17.62	$ 15.85	11.2%

(1) See Appendix B for projected benefit cost build-up.

APPENDIX B

Appendix B-1
State of Idaho
Department of Health and Welfare
SFY 2020 Dental Rate Development
DBA-submitted claims data incurred July 2018 to June 2019; paid through February 2020

Age Group: Adult
Benefit Package: Combined

SFY 2019 Member Months 872,518
SFY 2020 Projected Member Months 878,448

Covered Class & Service Category	SFY 2019 Data Util./ 1000	SFY 2019 Data Avg Cost Service	SFY 2019 Data Paid PMPM	Adjustment Factors Fee Sch	Trend Util.	Trend Cost	SFY 2020 Cost Projection Util./ 1000	SFY 2020 Cost Projection Avg Cost Service	SFY 2020 Cost Projection Paid PMPM	Expansion Rate Projection Ramp-up Factor	Expansion Rate Projection Proj PMPM
Class I											
Oral Evaluations	207.3	$25.17	$0.43	1.000	1.030	1.000	213.5	$25.17	$0.45	0.950	$0.43
X-Rays	285.4	21.43	0.51	1.000	1.030	1.000	294.0	21.43	0.52	0.950	0.50
Lab and Other Tests	0.0	-	-	1.000	1.030	1.000	0.0	-	-	0.950	-
Prophylaxis	132.3	41.62	0.46	1.000	1.030	1.000	136.3	41.62	0.47	0.950	0.45
Fluoride	32.4	13.54	0.04	1.000	1.030	1.000	33.4	13.54	0.04	0.950	0.04
Sealants	0.0	-	-	1.000	1.030	1.000	0.0	-	-	0.950	-
Subtotal	**657.5**	**$26.28**	**$1.44**	**1.000**	**1.030**	**1.000**	**677.2**	**$26.28**	**$1.48**	0.950	**$1.41**
Class II											
Space Maintainers	0.0	$0.00	$0.00	1.000	1.015	1.000	0.0	$0.00	$0.00	0.855	$0.00
Restorations	294.0	57.65	1.41	1.347	1.015	1.000	298.4	77.64	1.93	0.855	1.65
Endodontics	1.6	49.61	0.01	1.000	1.015	1.000	1.6	49.61	0.01	0.855	0.01
Periodontics	54.7	59.26	0.27	1.000	1.015	1.000	55.5	59.26	0.27	0.855	0.23
Emergency (Palliative)	0.9	34.73	0.00	1.000	1.015	1.000	1.0	34.73	0.00	0.855	0.00
Anesthesia	32.8	43.55	0.12	1.300	1.015	1.000	33.3	56.61	0.16	0.855	0.13
Simple Extractions	152.8	59.17	0.75	1.300	1.015	1.000	155.1	76.90	0.99	0.855	0.85
Surgical Extractions	128.2	87.04	0.93	1.242	1.015	1.000	130.1	108.06	1.17	0.855	1.00
Oral Surgery	0.4	66.70	0.00	1.000	1.015	1.000	0.4	66.70	0.00	0.855	0.00
Subtotal	**665.4**	**$63.05**	**$3.50**	**1.279**	**1.015**	**1.000**	**675.4**	**$80.65**	**$4.54**	0.855	**$3.88**
Class III											
Inlays/Onlays/Crowns	0.0	$0.00	$0.00	1.000	0.995	1.000	0.0	$0.00	$0.00	0.855	$0.00
Repair (Simple)	1.4	35.76	0.00	1.000	0.995	1.000	1.4	35.76	0.00	0.855	0.00
Dentures	51.4	432.94	1.85	1.097	0.995	1.000	51.1	474.75	2.02	0.855	1.73
Other Prosthetics	1.8	23.08	0.00	1.000	0.995	1.000	1.8	23.08	0.00	0.855	0.00
Bridges	0.0	-	-	1.000	0.995	1.000	0.0	-	-	0.855	-
Subtotal	**54.6**	**$409.02**	**$1.86**	**1.096**	**0.995**	**1.000**	**54.4**	**$448.36**	**$2.03**	0.855	**$1.74**
Class IV											
Orthodontics	0.0	$0.00	$0.00	1.000	1.025	1.000	0.0	$0.00	$0.00	1.000	$0.00
Subtotal	**0.0**	**$0.00**	**$0.00**	**1.000**	**1.025**	**1.000**	**0.0**	**$0.00**	**$0.00**	1.000	**$0.00**
Other											
D9999 Encounter	327.4	$229.58	$6.26	1.000	1.025	1.000	335.5	$229.58	$6.42	0.912	$5.86
Unclassified	34.1	30.54	0.09	1.171	1.025	1.000	34.9	35.77	0.10	0.912	$0.09
Subtotal	**361.4**	**$210.83**	**$6.35**	**1.002**	**1.025**	**1.000**	**370.4**	**$211.32**	**$6.52**	0.912	**$5.95**
Grand Total	**1,738.9**	**$90.73**	**$13.15**				**1,777.4**	**$98.41**	**$14.58**	0.890	**$12.98**

Appendix B-2
State of Idaho
Department of Health and Welfare
SFY 2020 Dental Rate Development
DBA-submitted claims data incurred July 2018 to June 2019; paid through February 2020

Age Group:	**Child**	**SFY 2019 Member Months**	2,074,901
Benefit Package:	**Basic**	**SFY 2020 Projected Member Months**	1,898,044

	SFY 2019 Data			Adjustment Factors			SFY 2020 Cost Projection		
					Trend				
Covered Class & Service Category	**Util./ 1000**	**Avg Cost Service**	**Paid PMPM**	**Fee Sch**	**Util.**	**Cost**	**Util./ 1000**	**Avg Cost Service**	**Paid PMPM**
Class I									
Oral Evaluations	842.8	$21.52	$1.51	1.000	1.030	1.000	868.0	$21.52	$1.56
X-Rays	1,604.6	14.03	1.88	1.000	1.030	1.000	1,652.7	14.03	1.93
Lab and Other Tests	0.9	10.20	0.00	1.000	1.030	1.000	1.0	10.20	0.00
Prophylaxis	739.7	32.73	2.02	1.000	1.030	1.000	761.9	32.73	2.08
Fluoride	740.1	13.46	0.83	1.000	1.030	1.000	762.3	13.46	0.86
Sealants	606.4	20.76	1.05	1.000	1.030	1.000	624.6	20.76	1.08
Subtotal	**4,534.5**	**$19.28**	**$7.28**	**1.000**	**1.030**	**1.000**	**4,670.5**	**$19.28**	**$7.50**
Class II									
Space Maintainers	11.1	$99.21	$0.09	1.000	1.015	1.000	11.3	$99.21	$0.09
Restorations	504.9	51.86	2.18	1.282	1.015	1.000	512.4	66.46	2.84
Endodontics	50.9	89.41	0.38	1.000	1.015	1.000	51.7	89.41	0.39
Periodontics	1.1	64.50	0.01	1.000	1.015	1.000	1.1	64.50	0.01
Emergency (Palliative)	0.2	34.73	0.00	1.000	1.015	1.000	0.2	34.73	0.00
Anesthesia	29.3	48.20	0.12	1.300	1.015	1.000	29.7	62.66	0.16
Simple Extractions	96.9	44.06	0.36	1.225	1.015	1.000	98.3	53.99	0.44
Surgical Extractions	32.5	135.90	0.37	1.024	1.015	1.000	33.0	139.20	0.38
Oral Surgery	1.5	96.39	0.01	1.000	1.015	1.000	1.5	96.39	0.01
Subtotal	**728.3**	**$57.88**	**$3.51**	**1.210**	**1.015**	**1.000**	**739.2**	**$70.05**	**$4.32**
Class III									
Inlays/Onlays/Crowns	182.3	$93.90	$1.43	1.150	0.995	1.000	181.4	$107.99	$1.63
Repair (Simple)	2.1	30.33	0.01	1.000	0.995	1.000	2.0	30.33	0.01
Dentures	0.1	342.32	0.00	1.000	0.995	1.000	0.1	342.32	0.00
Other Prosthetics	0.0	40.19	0.00	1.000	0.995	1.000	0.0	40.19	0.00
Bridges	0.0	-	-	1.000	0.995	1.000	0.0	-	-
Subtotal	**184.5**	**$93.30**	**$1.43**	**1.149**	**0.995**	**1.000**	**183.5**	**$107.22**	**$1.64**
Class IV									
Orthodontics	24.8	$111.82	$0.23	1.000	1.025	1.000	25.4	$111.82	$0.24
Subtotal	**24.8**	**$111.82**	**$0.23**	**1.000**	**1.025**	**1.000**	**25.4**	**$111.82**	**$0.24**
Other									
D9999 Encounter	104.3	$248.38	$2.16	1.000	1.025	1.000	106.9	$248.38	$2.21
Unclassified	216.2	28.17	0.51	1.203	1.025	1.000	221.6	33.90	0.63
Subtotal	**320.5**	**$99.83**	**$2.67**	**1.039**	**1.025**	**1.000**	**328.5**	**$103.69**	**$2.84**
Grand Total	**5,792.6**	**$31.34**	**$15.13**				**5,947.2**	**$33.36**	**$16.53**

Appendix B-3
State of Idaho
Department of Health and Welfare
SFY 2020 Dental Rate Development
DBA-submitted claims data incurred July 2018 to June 2019; paid through February 2020

Age Group:	**Child**	**SFY 2019 Member Months**	336,527
Benefit Package:	**Enhanced**	**SFY 2020 Projected Member Months**	310,219

	SFY 2019 Data			Adjustment Factors			SFY 2020 Cost Projection		
					Trend				
Covered Class & Service Category	**Util./ 1000**	**Avg Cost Service**	**Paid PMPM**	**Fee Sch**	**Util.**	**Cost**	**Util./ 1000**	**Avg Cost Service**	**Paid PMPM**
Class I									
Oral Evaluations	803.1	$21.26	$1.42	1.000	1.030	1.000	827.2	$21.26	$1.47
X-Rays	1,434.5	15.76	1.88	1.000	1.030	1.000	1,477.5	15.76	1.94
Lab and Other Tests	0.1	10.20	0.00	1.000	1.030	1.000	0.1	10.20	0.00
Prophylaxis	697.3	35.49	2.06	1.000	1.030	1.000	718.2	35.49	2.12
Fluoride	673.2	13.50	0.76	1.000	1.030	1.000	693.4	13.50	0.78
Sealants	695.6	20.77	1.20	1.000	1.030	1.000	716.4	20.77	1.24
Subtotal	**4,303.8**	**$20.44**	**$7.33**	**1.000**	**1.030**	**1.000**	**4,432.9**	**$20.44**	**$7.55**
Class II									
Space Maintainers	7.7	$102.69	$0.07	1.000	1.015	1.000	7.8	$102.69	$0.07
Restorations	587.8	52.24	2.56	1.276	1.015	1.000	596.6	66.66	3.31
Endodontics	28.1	159.40	0.37	1.000	1.015	1.000	28.5	159.40	0.38
Periodontics	4.0	63.21	0.02	1.000	1.015	1.000	4.1	63.21	0.02
Emergency (Palliative)	0.2	34.73	0.00	1.000	1.015	1.000	0.3	34.73	0.00
Anesthesia	48.3	45.67	0.18	1.300	1.015	1.000	49.0	59.37	0.24
Simple Extractions	96.7	44.14	0.36	1.224	1.015	1.000	98.2	54.03	0.44
Surgical Extractions	75.7	136.27	0.86	1.029	1.015	1.000	76.9	140.22	0.90
Oral Surgery	1.6	87.39	0.01	1.000	1.015	1.000	1.6	87.39	0.01
Subtotal	**850.2**	**$62.54**	**$4.43**	**1.195**	**1.015**	**1.000**	**862.9**	**$74.76**	**$5.38**
Class III									
Inlays/Onlays/Crowns	89.9	$109.29	$0.82	1.150	0.995	1.000	89.5	$125.68	$0.94
Repair (Simple)	1.9	30.66	0.00	1.000	0.995	1.000	1.9	30.66	0.00
Dentures	0.1	292.71	0.00	1.000	0.995	1.000	0.1	292.71	0.00
Other Prosthetics	0.0	100.22	0.00	1.000	0.995	1.000	0.0	100.22	0.00
Bridges	0.0	-	-	1.000	0.995	1.000	0.0	-	-
Subtotal	**92.0**	**$107.89**	**$0.83**	**1.149**	**0.995**	**1.000**	**91.5**	**$123.92**	**$0.94**
Class IV									
Orthodontics	54.4	$126.76	$0.57	1.000	1.025	1.000	55.7	$126.76	$0.59
Subtotal	**54.4**	**$126.76**	**$0.57**	**1.000**	**1.025**	**1.000**	**55.7**	**$126.76**	**$0.59**
Other									
D9999 Encounter	130.5	$239.79	$2.61	1.000	1.025	1.000	133.8	$239.79	$2.67
Unclassified	194.0	28.79	0.47	1.204	1.025	1.000	198.9	34.67	0.57
Subtotal	**324.5**	**$113.65**	**$3.07**	**1.031**	**1.025**	**1.000**	**332.6**	**$117.16**	**$3.25**
Grand Total	**5,624.8**	**$34.64**	**$16.24**				**5,775.7**	**$36.79**	**$17.71**

APPENDIX C

Milliman

CMS Checklist Response
Capitated Contracts Rate Setting

Subsection AA.1 – General

AA.1.0 Overview of Ratesetting Methodology

The following is a high-level description of the approach used to develop actuarially sound dental capitation rates for the Idaho Department of Health and Welfare (DHW). The contract period for the capitation rates is state fiscal year (SFY) 2020 (July 1, 2019 through June 30, 2020). The contracting dental benefit administrator (DBA) is assuming full risk for all covered state plan dental services for enrolled members.

Critical steps in the rate development process included the following:

- Managed Care of North America (MCNA), the contracted DBA, provided detailed historical claim experience.
- DHW provided detailed historical eligibility data for covered Medicaid clients.
- The experience was adjusted to reflect the services covered for each group. Any non-covered expenses were removed from the base data.
- The cost projections included adjustments for trend, fee schedule changes, Expansion ramp-up, and health plan non-benefit costs.

The rate setting steps are described in greater detail throughout the remainder of this document.

AA.1.1 ***Actuarial Certification***

This document is an appendix to the actuarial certification.

AA.1.2 ***Projection of Expenditures***

Our estimate of projected total costs for the contract period of SFY 2020, which covers 12 months of payments, is $63.5 million on a gross-of-withhold basis. See Table 3 in Section I.1.B.ii of the certification for estimated State and Federal expenditures by aid category.

AA.1.3 ***Procurement, Prior Approval and Ratesetting***

The method employed by the State in contracting with MCNA is the method listed in the *Financial Review Documentation for At-Risk Capitated Contracts Rate Setting* as Option 2: Competitive Procurement.

AA.1.5 ***Risk Contracts***

The assumption of full risk for the cost of services covered under the contract is specified in the contract.

AA.1.6 ***Limit on Payment to Other Providers***

The State of Idaho makes no payments to providers other than the contracted entity for the services covered under the contract.

AA.1.7 *Rate Modifications*

The first six months of these rates are intended to supersede the prior certification for CY 2019. The last six months of these rates are not a rate amendment or an update to a prior certification

Subsection AA.2 – Base Year Utilization and Cost Data

AA.2.0 *Base Year Utilization and Cost Data*

Milliman has relied on claims provided by MCNA and eligibility data provided by DHW for the experience period, SFY 2019 (July 1, 2018 through June 30, 2019). This data is specific to the population eligible for enrollment in the managed care program.

Utilization data

Utilization data are appropriate to the Medicaid population, as described above.

Service Cost

Service cost assumptions are appropriate to the Medicaid population, as described above.

AA.2.1 *Medicaid Eligibles under the Contract*

The base year of data includes only Medicaid eligible members.

AA.2.2 *Dual Eligibles (DE)*

Dual eligibles are enrolled in the dental managed care program if they meet other eligibility requirements.

AA.2.3 *Spenddown*

Spenddown eligibles are not enrolled in the dental managed care program.

AA.2.4 *State Plan Services Only*

No services outside the state plan are included in the rate development. This includes in lieu of services, which are not included in the rate development. Only covered dental services have been included in the analysis.

AA.2.5 *Services that may be Covered by a Capitated Entity out of Contract Savings*

No services outside the state plan are included in the rate development. Additional services outside of the state plan are provided by the current capitated entity out of contract savings, but these will be determined independent of the rate setting process.

Subsection AA.3 – Adjustments to the Base Year Data

AA.3.0 *Adjustments to the Base Year Data*

Different covered services are allowed for different populations in the contract period, as was the case during the experience period. We restricted the claims data to only the covered benefits shown in the Idaho Smiles Medicaid Dental Program Participant Handbook.

AA.3.1 *Benefit Differences*

There are no benefit differences anticipated between the base year and the contract year.

AA.3.2 Administrative Cost Allowance Calculations

See Section I.5.B.i of the certification.

AA.3.3 *Special Populations' Adjustments*

No adjustments were made to the data for special populations.

AA.3.4 *Eligibility Adjustments*

There are no material changes in the eligible population from the data collection period to the current point in time for non-Expansion rate cells. Effective January 1, 2020, Expansion members became eligible for Medicaid, which did not require adjustments to historical eligibility data.

AA.3.5 *DSH Payments*

No funding for DSH payments is included in the capitation rate development.

AA.3.6 *Third Party Liability (TPL)*

The DBA will act as the State's agent to collect TPL for all enrolled Medicaid recipients. The DBA's capitated payments have been computed based on claim experience that is net of these collections. The vendor is instructed to vigorously pursue billing prior resources as these amounts are considered part of their capitation.

AA.3.7 *Copayments, Coinsurance and Deductibles in Capitated Rates*

The program includes no member copayments, coinsurance or deductibles.

AA.3.8 *Graduate Medical Education (GME)*

No GME payments are included in the historical experience data or in the proposed capitation rates.

AA.3.9 *FQHC and RHC reimbursement*

The State has confirmed that the DBA is to comply with the FQHC/RHC payment requirements as described in the contract.

AA.3.10 *Medical Cost/Trend Inflation*

See Section I.3.B.iii of the certification.

AA.3.11 ***Utilization Adjustments***

See Section I.3.B.iii of the certification.

AA.3.12 ***Utilization and Cost Assumptions***

See Section I.3.B.iii of the certification.

AA.3.13 ***Post-Eligibility Treatment of Income (PETI)***

Per the State of Idaho, PETI is not applicable to this program.

AA.3.14 ***Incomplete Data Adjustment***

All data were considered complete. See Section I.2.B.iii of the certification.

Subsection AA.4 – Establish Rate Category Groupings

AA.4.0 *Establish Rate Category Groupings*

The State of Idaho has four rate cells: Adults, Expansion, Children - Basic, and Children - Enhanced. The Expansion (New Adult Group / VIII Group) population category is being included for the first time, since they will receive coverage effective January 1, 2020.

AA.4.1 *Age*

No age adjustment factors beyond child and adult rate groupings were applied. Rates are negotiated separately for each rate cell.

AA.4.2 *Gender*

No gender adjustment factors are planned at this time as the program is mandatory, operated through a single vendor and covers a specific population.

AA.4.3 *Locality/Region*

No locality/region adjustment factors are planned at this time. The program is mandatory, statewide and covers a specific population.

AA.4.4 *Eligibility Categories*

We have divided the eligibles into four rate cells:

- Adult
- Expansion
- Children - Basic
- Children - Enhanced

Section AA.5 – Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0 *Data Smoothing*

No data smoothing efforts were required in the rate development process.

AA.5.1 *Special Populations and Assessment of the Data for Distortions*

N/A

AA.5.2 *Cost-neutral Data Smoothing Adjustment*

N/A

AA5.3 *Risk-Adjustment*

Risk adjustment is not appropriate for this program.

Subsection AA.6 – Stop Loss, Reinsurance, or Risk-sharing Arrangements

AA.6.0 *Stop Loss, Reinsurance, or Risk-sharing Arrangements*

See Section I.4.C of the certification.

AA.6.1 *Commercial Reinsurance*

N/A

AA.6.2 *Simple Stop Loss Program*

N/A

AA.6.3 *Risk Corridor Program*

N/A

Subsection AA.7 – Incentive Arrangements

AA.7.0 *Incentive Arrangements*

See Section I.4.B.i of the certification for a description of the vendor's withhold arrangement.

Attachment 4 - 20201218 Dental Capitation Rate Certification

MILLIMAN REPORT

Idaho Medicaid Managed Care: SFY 2021 Dental Capitation Rate Development

Idaho Smiles

STATE OF IDAHO, DEPARTMENT OF HEALTH AND WELFARE

December 2020

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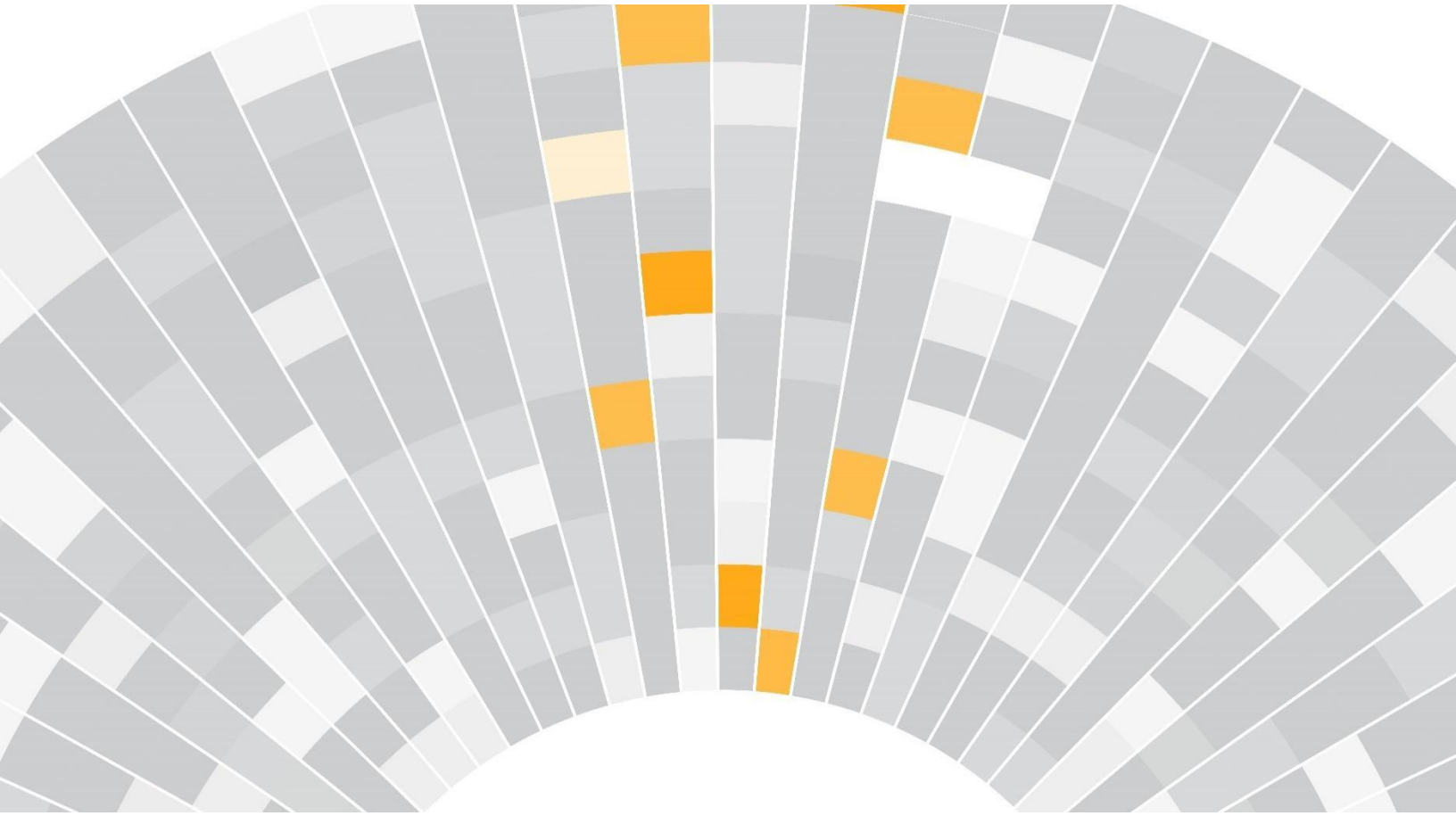

Milliman

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Executive Summary

INTRODUCTION

The Idaho Department of Health and Welfare (DHW) retained Milliman, Inc. (Milliman) to develop actuarially sound dental capitation rates. This report provides the supporting documentation for capitation rates which will be paid to the dental benefit administrator (DBA) during the state fiscal year (SFY) 2021 contract period (July 1, 2020 through June 30, 2021).

The rates include an adjustment for the impact of COVID-19 on utilization of services during SFY 2021. This adjustment applies to and is spread across the entire rating period.

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2020-2021 Medicaid Managed Care Rate Development Guide (CMS Guide), published July 2020:

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
- The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

CMS Guide Index [Section I.1.B.ii]

We indexed each section of this report to the corresponding section of the "2020-2021 Medicaid Managed Care Rate Development Guide". Throughout this report, sub-headings (like the one above) are utilized to identify the items described within the CMS Guide in order to index each section within this report's table of contents. For example, the contents within the brackets above refer to Section I, subsection 1 "General Information", bullet B "Appropriate Documentation". This notation appears in the table of contents with page number references, as well as the body of this rate certification for easy navigation.

CAPITATION RATES

Table 1 illustrates composite dental capitation rates effective July 1, 2020 through June 30, 2021 by aid category. Composite values have been calculated utilizing our projected SFY 2021 membership distribution. Note that the SFY 2020 rates shown are net of withhold.

TABLE 1: PROPOSED SFY 2021 DENTAL CAPITATION RATES

AID CATEGORY	PROJ SFY 2021 MM	SFY 2020 RATE	SFY 2021 RATE	RATE CHANGE
Adults	890,774	$ 16.35	$ 14.80	-9.5%
Expansion	1,034,213	14.55	16.43	13.0%
Children – Basic	1,926,521	18.44	18.20	-1.3%
Children – Enhanced	307,899	20.23	17.71	-12.5%
Composite	**4,159,407**	**$17.16**	**$17.00**	**-0.9%**

SUMMARY OF CHANGES

The following methodology changes were made for rate development effective during the SFY 2021 contract period relative to the SFY 2020 rate development:

- An adjustment for the impact of COVID-19 was added, to account for lower expected utilization compared to the base experience.
- Expansion started January 1, 2020 and generally we see pent-up demand as the result of members receiving coverage. Due to COVID, members were not able to receive the volume of services expected due to pent-up demand since COVID resulted in a reduction in utilization. Therefore, we have assumed pent-up demand factors for Expansion to reflect delayed pent-up demand.

Tables 2a and 2b illustrate the stepwise impacts of the individual adjustments in the development of the SFY 2021 proposed capitation rates relative to the base data experience period: incurred July 2018 – June 2019, paid through February 2020. Each row reflects the amount a key assumption contributes to the overall rate.

TABLE 2A: STEPWISE IMPACTS ON SFY 2021 RATES, PMPM

COMPONENT	ADULT	EXPANSION	CHILDREN - BASIC	CHILDREN - ENHANCED	COMPOSITE
Projected SFY 2021 MM	890,774	1,034,213	1,926,521	307,899	4,159,407
Base Data	$13.15	$13.15	$15.13	$16.24	$14.29
Trend	0.33	0.33	0.61	0.66	0.48
Fee Schedule Change	1.40	1.40	1.30	1.33	1.35
Expansion Pent-Up Demand	n/a	1.65	n/a	n/a	0.41
COVID-19 Adjustment	(1.93)	(2.15)	(1.11)	(2.73)	(1.66)
Administrative Load	1.85	2.05	2.28	2.21	2.12
Final Rate	**$14.80**	**$16.43**	**$18.20**	**$17.71**	**$17.00**

TABLE 2B: STEPWISE IMPACTS ON SFY 2021 RATES, %

COMPONENT	ADULT	EXPANSION	CHILDREN - BASIC	CHILDREN - ENHANCED	COMPOSITE
Projected SFY 2020 MM	890,774	1,034,213	1,926,521	307,899	4,159,407
Base Data	88.9%	80.0%	83.1%	91.7%	84.1%
Trend	2.2%	2.0%	3.3%	3.7%	2.8%
Fee Schedule Change	9.5%	8.5%	7.2%	7.5%	8.0%
Expansion Pent-Up Demand	n/a	10.0%	n/a	n/a	2.4%
COVID-19 Adjustment	(13.1%)	(13.1%)	(6.1%)	(15.4%)	(9.8%)
Administrative Load	12.5%	12.5%	12.5%	12.5%	12.5%
Composite	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

FISCAL IMPACT

Table 3 illustrates estimated State and Federal expenditures by aid category for the twelve-month contract period from July 1, 2020 to June 30, 2021. We have projected SFY 2021 expenditures using SFY 2021 enrollment projections from DHW. State-only expenditures were estimated using the following estimated SFY 2021 FMAP rates, which are a blend of federal fiscal year (FFY) 2020[1] and FFY 2021[2] FMAP rates for TANF and Check-up populations, and CY 2021 for Expansion:

- Adult (Standard) – 70.39%
- Expansion – 90.00%[3]
- Child (Standard) – 70.39%
- CHIP – 82.15%

1 https://www.federalregister.gov/documents/2018/11/28/2018-25944/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for
2 https://www.federalregister.gov/documents/2019/12/03/2019-26207/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for
3 https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/

TABLE 3: SFY 2021 DENTAL RATES, FEDERAL VS. STATE EXPENDITURES ($ MILLIONS)

AID CATEGORY	PROJ SFY 2021 MM	SFY 2021 PROPOSED RATE PMPM	SFY 2021 TOTAL EXP. ($M)	SFY 2021 FMAP	SFY 2021 STATE EXP. ($M)	SFY 2021 FED EXP. ($M)
Adult	890,774	$ 14.80	$ 13.2	70.4%	$ 3.9	$ 9.3
Expansion	1,034,213	16.43	17.0	90.0%	1.7	15.3
Children - Basic	1,926,521	18.20	35.1	72.0%	9.8	25.2
Children - Enhanced	307,899	17.71	5.5	70.9%	1.6	3.9
Composite	**4,159,407**	**$17.00**	**$ 70.7**	**75.9%**	**$ 17.0**	**$ 53.7**

APPENDICES

Appendix A provides the SFY 2021 capitation rates by rate cell compared to the SFY 2020 capitation rates. It also illustrates the steps applied to benefit cost projections subsequent to Appendix B to develop monthly capitation rates, including the application of administration/margin load and the COVID-19 adjustment.

Appendix B includes actuarial models by rate cell, which illustrate the development of each rate cell's SFY 2021 cost projection from base year experience and adjustments.

Appendix C includes responses to the CMS rate setting checklist.

Medicaid Managed Care Rates [Section I]

GENERAL INFORMATION [SECTION I.1]

General – Rate Development Standards [Section I.1.A]

Rating Period [Section I.1.A.i]:

This rate certification is for a 12-month rating period effective during SFY 2021.

Items included in an acceptable rate certification [Section I.1.A.ii]:

(a) A letter from the certifying actuary

This report concludes with a letter signed by the certifying actuary, Benjamin Diederich, who meets the requirements for an actuary in 42 CFR §438.2. The letter certifies that the final capitation rates meet the standards in 42 CFR §438.3(c), 438.3(e), 438.4, 438.5, 438.6, and 438.7.

(b) Final and certified capitation rates

Appendix A presents final and certified rates to be included in the DBA contract for all rate cells in accordance with 42 CFR §438.4(b)(4).

Table 1 illustrates a summary of proposed composite capitation rates compared to the prior period rates using projected SFY 2021 member months.

(c) Description of the program

(i) A summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

(A) The types and numbers of managed care plans included in the rate development:

Effective February 1, 2017, DHW is contracted with one DBA: Managed Care of North America (MCNA).

(B) A general description or list of the benefits that are required to be provided by the managed care plan or plans:

Idaho Medicaid covers dental services for adults and children as shown in Table 4 below. Pregnant women receive extra benefits through the Bright Beginnings Program.

TABLE 4: SFY 2021 MEDICAID COVERED DENTAL BENEFITS[4]

DESCRIPTION	CHILD COVERAGE	ADULT/EXPANSION COVERAGE
Routine Dental Exams	1 per 6 months	1 per year
Dental Cleanings	1 per 6 months	1 per 6 months
Fluoride	1 per 6 months	Not covered
Dental Sealants	Permanent molars; 1 per 36 months; ages 5-14	Not covered
Bitewing X-Rays	1 set per 6 months	1 set per 12 months
Full Mouth Series X-Rays or Equivalent	1 per 36 months	1 per 36 months
Fillings	1 per tooth per 24 months	1 per tooth per 24 months
Crowns	1 per tooth per 84 months	Not covered
Root Canals	1 per tooth per lifetime	Not covered
Root Planing and Scaling	1 per 24 months per quadrant	Not covered
Dentures	1 per 84 months	1 per 84 months
Extractions	1 per tooth per lifetime	1 per tooth per lifetime
Braces	Once per lifetime, if medically necessary	Not covered
Anesthesia	If approved, as medically necessary	If approved, as medically necessary
House, Hospital, Extended Facility Call	Not covered	1 per day
Behavior Management	Not covered	2 per year

(C) The areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

Managed care dental is provided through MCNA statewide. Idaho's dental benefit has been in managed care starting in SFY 2008, though not all populations transitioned to managed care at the same time.

(ii) Rating period:

The rating period covered by this rate certification is SFY 2021.

(iii) Covered populations:

The populations covered under the managed care program documented herein include:

- Section 1931 children
- Section 1931 adults
- Blind/disabled adults and children
- Aged beneficiaries
- Foster care children
- Title XXI State Children's Health Insurance Program (SCHIP)
- Medicare-Medicaid dual eligible adult participants who have chosen not to enroll in another managed care plan

(iv) Eligibility and enrollment criteria:

Enrollment in dental managed care is mandatory for all eligible populations.

(v) Special contract provisions under 42 CFR §438.6:

There are no new special contract provisions related to capitation rate development that were implemented into the DBA contract relative to the SFY 2020 contract.

4 http://docs.mcna.net/handbooks/mh-id-en, accessed March 14, 2020

The DBA contract does not include any of the following special contract provisions:

- Incentive arrangements
- State-directed payments
- Pass-through payments

(vi) Retroactive adjustments to capitation rates:

There are no retroactive adjustments applicable to the SFY 2021 capitation rates that are known at this time.

Differences among covered populations [Section I.1.A.iii]:

Any observed differences among covered populations are based on valid assumption differences driven by historical experience data or market research.

Cross-subsidization [Section I.1.A.iv]:

Capitation rates were developed such that payments from any rate cell do not cross-subsidize payments from any other rate cell.

Consistency of effective dates [Section I.1.A.v]:

The effective dates of changes to the Medicaid dental program (including eligibility, benefits, payment rate requirements, incentive programs, and program initiatives) are consistent with the assumptions used to develop the capitation rates. These changes have been presented in the Executive Summary, with detail included within the assumption documentation sections.

Minimum medical loss ratio [Section I.1.A.vi]:

Capitation rates have been developed in such a way that MCNA is expected to reasonably achieve a medical loss ratio (MLR) of at least 85% for the contract period, as calculated under 42 CFR §438.8.

The target pricing MLR is estimated to be 87.5% in aggregate prior to accounting for quality improvement and taxes and fees, and the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

The state will collect a remittance for the applicable years in which the vendor's MLR falls below 85%. More information is provided under Section I.4.C.ii.b of this rate report. This risk-sharing mechanism mitigates the risk to the state of claims being lower than expected, as experienced during the COVID-19 public health emergency.

Considerations for CMS approval [Section I.1.A.vii]:

As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:

(a) all adjustments are reasonable, appropriate, and attainable in the actuary's judgment.

All adjustments applied during the capitation rate development have been documented herein and are certified as part of the overall rates as reasonable, appropriate, and attainable by the certifying actuary.

(b) adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.

Additional adjustments to the capitation rates outside the rate setting process have not been made. If additional adjustments are made to the capitation rates prior to the end of the contract period, appropriate documentation will be submitted outlining any data, assumptions, methodology, and impact to the capitation rates.

(c) consistent with 42 CFR §438.7(c), the final contracted rates in each cell must either match the capitation rates in the rate certification. This is required in total and for each and every rate cell.

It is our understanding that the final contracted rates paid to MCNA for each rate cell will be consistent with the capitation rates included in Appendix A.

Certification period [Section I.1.A.viii]:

Rates are effective and certified for SFY 2021.

Procedures for rate certifications for rate and contract amendments [Section I.1.A.ix]:

(a) Federal financial participation (FFP)

The state has claimed Federal financial participation for capitation rates within the time limit.

(b) requirement for a new rate certification when rates change

If capitation rates change within SFY 2021 for reasons other than those outlined below in Section I.1.A.ix.(c), the state will submit a rate certification amendment outlining the data, assumptions, methodologies, and adjusted capitation rates as appropriate.

(c) supporting documentation for contract changes that revise covered populations or services under the contract

For contract amendments that do not affect rates, a new rate certification will not be developed. However, if a contract amendment revises covered populations or services under the contract, the certifying actuary will review the potential for a material capitation rate impact and provide an actuarial report documenting the data, assumptions, and methodologies used to evaluate the contract provisions.

(d) circumstances not requiring a new rate certification

(i) increase or decrease within 1.5% corridor

If capitation rates are adjusted within a 1.5% corridor of the base certification, the state's actuary will document rate changes within 1.5% of the originally certified rates through an actuarial memorandum.

(ii) application of risk scores under an approved methodology

The state's actuary will provide an actuarial report documenting the development of risk adjustment factors, including the data, assumptions, and methodologies used to develop the factors.

(e) contract amendment for rate changes other than already approved payment terms

The state will submit a contract amendment for any change that is made to the program other than what is defined within this report.

(f) Program features invalidated by law

If program features are invalidated by courts of law, or by changes in federal statues, regulations or approvals, the state will submit a rate amendment adjusting capitation rates to remove costs specific to these programs.

General – Appropriate Documentation [Section I.1.B]

Documentation detail required [Section I.1.B.i]:
States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:

(a) Data used

Table 5 identifies the types and sources of data and information utilized in developing the SFY 2021 dental capitation rates.

TABLE 5: BASE DATA SOURCES

EXPERIENCE TYPE	DATA SOURCE	EXPERIENCE DATES	DATE RECEIVED
Encounter Data	MCNA	7/1/2018 – 2/29/2020	3/6/2020
Detailed Monthly Eligibility	DHW	7/1/2018 – 2/29/2020	10/24/2019 & 3/12/2020
Enrollment Forecast	DHW	SFY 2020	7/20/2020
Covered Services	DHW	SFY 2020	11/4/2019
Fee Schedules	MCNA	SFY 2020	3/3/2020
Aid Category Definitions	DHW	SFY 2020	2/24/2020
Administrative Cost Summary	MCNA	CY 2019	3/2/2020
Financial Summaries	MCNA	CY 2019	3/3/2020
Contract Between DHW and MCNA	DHW	N/A	3/11/2020
Capitation Payment Detail Files	DHW	7/1/2018 – 9/30/2019	10/24/2019
Capitation Payment Control Totals	DHW	SFY 2019-2020	7/23/2020
Historical MLR Information	DHW	2/1/2018 – 10/31/2020	12/2/2020

Membership Data

The state's detailed monthly eligibility file was used as the membership basis for these rates. Because this file reflects a member's full eligibility record, not just eligibility for managed care, we only included records from the eligibility file that also had an associated capitation payment. This impact of this filtering to managed-care-eligible member months is shown in Table 7.

MCNA Experience

The base year experience used to develop the SFY 2021 capitation rates consists of services incurred during SFY 2019, paid through February 2020. This base period was selected because it was the most recent and complete 12 months of managed care data available.

We worked to reconcile the SFY 2019 claims loaded into our system to claim summaries reported in financial documents presented by MCNA. Note that these reconciliations were performed by incurred month, which was the level of detail at which we received summary information. Differences between the two sources were small enough that they could be reasonably expected to be due to accounting differences, such as in incomplete data estimates.

MCNA did not engage in sub-capitated arrangements for any dental services or provider groups. All encounters used in the base period were paid by MCNA on a fee-for-service basis.

Other Sources

In addition to historical dental experience, we reviewed and considered National Health Expenditures[5] (NHE) data to help inform our trend rate selection.

(b) Assumptions made:

Details supporting all assumptions are provided throughout this document. The following assumptions have been addressed during rate development:

- Dental service trends
- Fee schedule changes
- Expansion pent-up demand
- Non-benefit expenses

(c) Methods for analyzing data and developing assumptions and adjustments:

Methodology applied in developing assumptions and adjustments are described throughout this document where assumptions are identified.

5 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

Assumption & adjustment ranges [Section I.1.B.ii]:

No ranges are specified within the rate report.

Rate certification index [Section I.1.B.iil]:

This report and its table of contents is the rate certification index.

Enhanced FMAP [Section I.1.B.iv]:

Populations eligible for enhanced FMAP under the DBA contract include the CHIP and Expansion (New Adult Group / VIII Group). Idaho's average effective FMAP rates for SFY 2021 by population are:

- Adult (Standard) – 70.39%
- Expansion – 90.00%[6]
- Child (Standard) – 70.39%
- CHIP – 82.15%

There are no services within the DBA contract that are eligible for enhanced FMAP.

Comparison to prior rating periods [Section I.1.B.v]

(a) Comparison to previous certified rates

The prior contract period was SFY 2020, with changes to capitation rates effective in SFY 2021.

Proposed capitation rates relative to prior capitation rates are illustrated in aggregate in Table 1 of the Executive Summary and Appendix A.

(b) Description of any material changes to the rates or rate development process compared to the prior rating period not addressed elsewhere

Material changes include:

- An adjustment for the impact of COVID-19 was added, to account for lower expected utilization compared to the base experience.
- Expansion started January 1, 2020 and generally we see pent-up demand as the result of members receiving coverage. Due to COVID, members were not able to receive the volume of services expected due to pent-up demand since COVID resulted in a reduction in utilization. Therefore, we have assumed pent-up demand factors for Expansion to reflect delayed pent-up demand.

List of known amendments [Section I.1.B.vi]:

Not applicable.

DATA [SECTION I.2]

Data – Rate Development Standards [Section 1.2.A]

Base data standards [Section I.2.A.i]:

(a) Validated data and audited financial reports

DHW and its vendors provided validated data for use in rate development. Section I.2.B discusses the provided data in more detail.

(b) Appropriate base data period

We reviewed historical data and selected a base period of July 1, 2018 to June 30, 2019, paid through February 29, 2020. We believe selection of this time period represents a credible base for projections, and it limits the development and application of adjustments that would be necessary if utilizing a longer time period.

(c) Appropriate base data population

The base data represents the same Medicaid population that will be enrolled in the program during the contract period.

(d) Alternative data sources

Not applicable.

6 https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/

Data – Appropriate Documentation [Section I.2.B]

Base data under 42 CFR §438.7(b)(1) [Section I.2.B.i]:

(a) A description of base data requested and used by the actuary

(i) A summary of the base data that was requested by the actuary.

Data requests were sent to DHW and MCNA. The items requested include:

- Detailed capitation membership and dental claims data from July 2017 – July 2019
  - Emerging experience was later requested in order to review the Expansion population experience through February 29, 2020
- Control totals/financial reports
- Historical G&A Expenses
- Copy of the most current benefit manual available
- Copy of the most recent fee schedule
- Clarification on how Expansion will be incorporated into the rate cell structure
- Anticipated experience for Expansion, and potential risk mitigation provisions
- Benefit changes and fee schedule changes between the base period and projection period
- Information on identifying FQHC encounters in the base data

Data was provided in full to the best of the state's and MCNA's abilities.

(ii) A summary of the base data that was provided by the state.

We received data directly from the state; however, it did not appear reasonable in aggregate. We are working with the state to reconcile its data to that provided by MCNA.

(iii) An explanation of why any base data requested was not provided by the state.

While the state does receive encounter data directly from MCNA, there were concerns with the ability to reconcile the data within the timeframe necessary for rate development. We are working with the state currently to reconcile their data for future use.

Description of data used to develop rates [Section I.2.B.ii]:

(a) Description of the data

(i) types of data used

We utilized managed care encounters, health plan financial statements, and state eligibility data in the development of capitation rates. Table 5 identifies additional details related to all data received.

(ii) age or time periods of all data used.

SFY 2019 eligibility and claims data served as the base data underlying the capitation rates presented herein.

(iii) sources of all data used (e.g., State Medicaid Agency; other state agencies; health plans; or other third parties).

Table 5 identifies the source of each individual data component utilized during rate development. All data was received from DHW or MCNA.

(iv) data used for subcapitated arrangements

All base claims data were provided by MCNA, which does not have subcapitation arrangements with any providers during either the base or rating period.

(b) Data quality and validation:

(i) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:

(A) completeness of the data.

(B) accuracy of the data.

(C) consistency of the data across data sources.

Per MCNA's contract with DHW, MCNA is required to certify encounter data, payment data, and all other information submitted to the state. Data is required to comply with the applicable certification requirements for data and documents specified by DHW pursuant to 42 C.F.R. § 438.604, 438.606 and 457.950(a)(2). MCNA provided the following information that we used in validating the data sources:

- Control totals for reconciliation:
  - Claim lag triangles
  - Member month control totals
- A reconciliation of control totals to the company financial statements
- An attestation of accuracy by a company officer

We have a series of internal data validation processes which were conducted upon receipt of each set of data from DHW and MCNA. We use reconciliation workbooks to fully reconcile costs and member month counts with the control totals from separate reports. We also perform reasonableness checks throughout the rate development as we review data and information at various levels to develop assumptions such as trend and completion factors. We maintain a collaborative relationship with the state and its contractors, such that we are able to discuss data review questions and concerns throughout the rate development process.

(ii) a summary of the actuary's assessment of the data.

As the certifying actuary, I have assessed the quality of available data to be sufficient for the purpose of developing projected costs for capitation rates effective during the SFY 2021 contract period. All data were reviewed at several professional levels by consultants, actuaries, and data analysts who have significant experience with Medicaid data. We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent.

(iii) any other concerns that the actuary has over the availability or quality of the data.

We do not have concerns about the availability or quality of the data used for our analysis.

(c) description of how the actuary determined what data was appropriate to use for the rating period:

(i) why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered

We utilized MCNA's encounter data as base experience data, which is the most representative source of future experience under the program as it is based on the population to be covered and services to be provided under the DBA contract in SFY 2021.

(ii) why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data

Not applicable.

(d) Reliance on a data book:

We did not rely on a data book.

Description of data adjustments [Section I.2.B.iii]:

(a) Credibility:

Each rate cell has enough membership in the base period to be considered fully credible without additional adjustment.

(a) Completion factors:

Because eight months had elapsed between the most recent month of data and when rates are developed, all data were considered complete and the completion impact was 0%. This assumption was corroborated by our review of historical claims runout patterns.

(b) Data errors:

We did not identify any errors in the data. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

(c) Program changes:

Effective July 1, 2019, MCNA increased the fees for certain Certified Dental Technicians (CDT) codes for both children and adults. To account for this fee schedule increase continuing into SFY 2021, we applied the percentage increase to our base data at the CDT-level. The impact of this fee schedule increase is shown in Table 6 below.

TABLE 6: IMPACT OF FEE SCHEDULE CHANGE

CATEGORY OF SERVICE	ADULT	EXPANSION	CHILDREN - BASIC	CHILDREN - ENHANCED	COMPOSITE
Class I	0.0%	0.0%	0.0%	0.0%	0.0%
Class II	27.9%	27.9%	21.0%	19.5%	24.1%
Class III	9.6%	9.6%	14.9%	14.9%	12.5%
Class IV	0.0%	0.0%	0.0%	0.0%	0.0%
Unclassified	0.2%	0.2%	3.9%	3.1%	2.1%
Composite	**8.9%**	**8.9%**	**7.0%**	**6.7%**	**7.8%**

(d) Exclusions:

The members eligible for this dental program were all managed-care-eligible Medicaid beneficiaries in Idaho except those identified in the detailed eligibility file as "Medicare only."

Only services that will be covered under the managed care contract were included in our analysis. Claims were excluded if they did not have a record in the eligibility file, or if they were flagged as non-covered based on the age of the recipient at the time of service. These exclusions are shown in Table 7 below.

TABLE 7: RAW DATA EXCLUSIONS

COMPONENT	MEMBERSHIP	CLAIMS
Raw Total	3,616,167	$ 48,853,920
No Associated Capitated Payment	332,149	377,050
Medicare Only	72	20,616
Non-Covered Service		130,335
Final Base Data	**3,283,946**	**$ 48,325,919**

PROJECTED BENEFIT COSTS AND TRENDS [SECTION I.3]

Projected Benefit Cost – Rate Development Standards [Section I.3.A]

Allowed services [Section I.3.A.i]:

Final capitation rates are based only upon State Plan services as defined in the DBA contract and based on 42 CFR §438.3(c)(1)(ii) and 438.3(e). Included services represent provider payment rates that have been assessed to adequately allow an efficient DBA to deliver services for Medicaid-eligible enrollees in compliance with contractual requirements.

MCNA does not cover any value-added benefits.

Assumption variation [Section I.3.A.ii]:

Variations in the assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations. Additional documentation for adjustment development is included in Section I.3.B.

Development of benefit cost trends [Section I.3.A.iii]:

Selected trend rates have been developed in accordance with 42 CFR §438.5(d) and generally accepted actuarial principles and practices. We have assessed them to be reasonable for the Medicaid program covered by this certification. We relied on information from similar Medicaid managed care programs, National Health Expenditures data, and the Milliman *Health Cost Guidelines - Dental* (Dental HCGs).

Additional documentation for trend rates is included in Section I.3.B.iii.

In-lieu-of services under 42 CFR §438.3(e)(2) [Section I.3.A.iv]:

The DBA contract does not include provision for services in-lieu of State Plan services.

IMD treatment as in-lieu-of service [Section I.3.A.v]:

Services provided at Institutions for Mental Disease (IMDs) are not covered under this contract.

Projected Benefit Cost – Appropriate Documentation [Section I.3.B]

Final projected benefit cost [Section I.3.B.i]:

Appendices A and B contain final projected benefit costs for the SFY 2021 contract period.

Development of projected benefit costs [Section I.3.B.ii]:

Section I.1.B.i.(a) includes a description of data used. Assumptions and methodologies are documented below, and elsewhere in this report in the applicable section.

(a) a description of the data, assumptions, and methodologies used to develop the projected benefit costs and, in particular, all significant and material items in developing the projected benefit costs.

The data used to develop dental projected benefit costs was managed care data—submitted by MCNA—from July 1, 2018 to June 30, 2019, paid through February 29, 2020. This data was grouped according to dental class, and rate cell. The data was summarized by utilization, unit cost and PMPM amounts. Encounters incurred at federally qualified health centers (FQHCs) were identified with the procedure code D9999 and grouped separately in cost models. The entire prospective payment system (PPS) rate paid to FQHCs is the responsibility of MCNA and is reflected in base data encounters.

Additionally, we relied on the Milliman *Health Cost Guidelines - Dental* (Dental HCGs) in conjunction with NHE data and projections to select trend assumptions. The Dental HCGs represent a conglomeration of data, research and actuarial judgement, and provide a flexible but consistent basis for projections for a wide variety of dental benefit plans. Included in the Dental HCGs are a range of trend factors for dental utilization, as well as considerations for how to select point estimates from these ranges based on an array of circumstances.

Though the Dental HCGs are developed for commercial dental rating structures, in the absence of more applicable Idaho Medicaid data, we assumed that similar secular trends would impact commercial and Medicaid markets. Given the large fee schedule increase between SFY 2019 and SFY 2021, and the vendor change in 2017, historical Idaho dental trends would not be a reliable predictor of future trend.

(b) any material changes to the data, assumptions, and methodologies used to develop projected benefit costs since the last rate certification must be described.

Material changes are listed in the Executive Summary and throughout this report.

(c) the amount of overpayments to providers and a description of how the state accounted for this in rate development. See §438.608(d).

MCNA did not report any overpayments to providers outside of adjustments captured in their detailed encounter data.

Projected benefit cost trends [Section I.3.B.iii]:

(a) In accordance with 42 CFR §438.7(b)(2), this section must include:

(i) Data and assumptions used to develop trends:

(A) Descriptions of data and assumptions.

Given the large fee schedule increase between SFY 2019 and SFY 2021, and the vendor change in 2017, historical Idaho dental trends would not be a reliable predictor of future trend. The discontinuities between the data from different delivery systems would be pronounced enough that a multi-year regression study is not appropriate for trend development.

Rather, we relied on the Milliman Dental HCGs, and reviewed for consistency with NHE trend projections, to select trend assumptions.

(B) Reliance on experience

As described above, we did not rely on historical experience for trend assumption development due to transitions in recent years.

(ii) Methodologies used to develop trends:

Trends were selected based on judgement, and comparison to external sources. The midpoint of the Milliman Dental HCG composite trend was comparable to the NHE composite trend, so these sources are consistent on a total PMPM basis. For rating, we selected the Milliman Dental HCG utilization trend component. We decided not to apply the HCG charge trends because of the large fee schedule increase.

Table 8 shows the total impact of trend.

TABLE 8: COMPOSITE ANNUAL TRENDS

CATEGORY OF SERVICE	ADULT	EXPANSION	CHILDREN - BASIC	CHILDREN - ENHANCED	COMPOSITE
Class I	3.0%	3.0%	3.0%	3.0%	3.0%
Class II	1.5%	1.5%	1.5%	1.5%	1.5%
Class III	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%
Class IV	0.0%	0.0%	1.2%	1.2%	0.6%
Unclassified	1.2%	1.2%	1.2%	1.2%	1.2%
Composite	**1.2%**	**1.2%**	**2.0%**	**2.0%**	**1.6%**

(iii) Comparisons to historical trends:

Given the large fee schedule increase between SFY 2019 and SFY 2021, and the vendor change in 2017, historical Idaho dental trends would not be a reliable predictor of future trend. The discontinuities between the data from different delivery systems would be pronounced enough that a multi-year regression study is not appropriate.

(iv) documentation supporting the chosen trend rates and explanation of outlier and negative trends.

There was a lack of appropriate historical data for developing trends. As a result, national trends from Milliman's Dental HCGs were selected after confirming the levels were consistent with those seen in NHE data.

(b) Components of trend:

The trends are only applied to utilization. Because of the large fee schedule increase, charge trends were considered unnecessary.

(c) Variations in trend:

Selected trends vary by dental service class: I, II, III, IV and unclassified.

These variations in trend were not due to differences in federal financial participation.

(d) Other material adjustments to trend:

We made an adjustment to account for COVID-19's impact on the rating period. This was developed based on reviewing member access rates in SFY 2019 and during SFY 2020 COVID months. The member access rate is calculated as the number of members with a claim in a month, divided by total eligible members in the month.

We took the following approach in developing the final adjustment factors by rate cell:

- Calculate the average access rates for SFY 2019 and the COVID period consisting of the months of March, May and June within SFY 2020
    - Note that April was excluded from the COVID period due to being the most impacted and having a significantly lower access rate than the other COVID months
- Take the percent difference in access rates between these two periods
- Dampen the percent difference between periods by 50%. We applied a dampening factor because:
    - We don't anticipate the same utilization reduction seen in the COVID period will persist throughout the entire SFY 2021 period.
    - We recognize the access rate does not perfectly reflect utilization impacts, as it doesn't account for the type or intensity of services being reduced.
- The adjustment was rounded to the nearest 0.5% when applying to the projected benefit costs
    - The adjustment for Expansion has been set equal to the Adult factor, as the emerging experience reviewed indicates the access to care ratios are most similar between these rate cells.

Table 9 illustrates the development of the adjustment.

TABLE 9: COVID-19 ADJUSTMENT DEVELOPMENT

AID CATEGORY	SFY 2019 ACCESS RATE	COVID ACCESS RATE	% DIFFERENCE	COVID ADJUSTMENT
Adults	5.3%	3.9%	-26.2%	-13.0%
Children – Basic	9.8%	8.5%	-13.5%	-6.5%
Children – Enhanced	11.3%	7.9%	-30.4%	-15.0%

If the SFY 2021 rates were paid during SFY 2020 (using SFY 2020 experience) we would project an overall MLR of approximately 81%.

(e) Other non-material adjustments to trend:

There were no non-material adjustments made to trend.

Adjustments due to MHPAEA [Section I.3.B.iv]:

Not applicable.

In-lieu-of services [Section I.3.B.v]:

There were no services provided in lieu of State Plan services under the DBA contract during the experience period.

Retrospective eligibility periods [Section I.3.B.vi]:

(a) MCOs' responsibility to pay for claims incurred during the retroactive eligibility period

Retrospective eligibility periods covering services incurred prior to a member's application submission and approval are covered under the FFS delivery system.

(b) How claims information are included in the base data

Claims for retrospective eligibility periods prior to approval of a Medicaid application are not included in our base experience.

(c) How enrollment or exposure information is included in the base data

Exposure months for retrospective eligibility periods prior to approval of a Medicaid application are not included in our base experience.

(d) How capitation rates are adjusted to reflect retroactive eligibility period

Capitation rates are not explicitly adjusted to reflect retroactive eligibility periods because the treatment of retroactive eligibility periods is not changing between the base period and the projection period.

Impact of changes to covered benefits or services [Section I.3.B.vii]:

(a) more or fewer State Plan benefits covered by Medicaid managed care

Not applicable.

(b) recoveries of overpayments made to providers by health plans

MCNA did not report provider overpayments that were not included in their detailed claims data.

(c) requirements related to payments from health plans to any providers or class of providers

Not applicable.

(d) requirements or conditions of any applicable waivers

The DBA contract is operated under the authority of a 1915(b) Waiver, with approval to require enrollees to obtain medical care through the DBA. Sections 1902(a)(23) (freedom of choice) and 1902(a)(4) (mandating enrollment in a single PAHP) of the Social Security Act have all been waived. SFY 2021 capitation rates were developed in accordance with the terms of the Waiver.

(e) requirements or conditions of any litigation to which the state is subjected

Not applicable.

Impact of non-material changes to covered benefits or services [Section I.3.B.viii]:

(a) aggregate adjustment for changes determined by the actuary to be non-material

(i) list of all non-material adjustments used in the rate development process

All adjustments used in developing projected benefit costs have been described elsewhere in this report. We have not aggregated multiple changes together in the development of adjustment factors.

(ii) description of why changes were considered non-material and how they were aggregated

Not applicable.

(iii) description of where in the rate-setting process adjustments were applied

Not applicable.

(iv) aggregate cost impact of non-material adjustments

Not applicable.

SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT [SECTION I.4]

Incentive Arrangements [Section I.4.A]

Incentive Arrangements – Rate Development Standards [Section I.4.A.i]

(a) description of incentives included in the contract between the state and the health plans

The DBA contract does not include any incentive arrangements for additional funds over and above the capitation rates tied to meeting performance targets.

(i) incentive payment amounts

There are no incentives included in the DBA contract

Incentive Arrangements – Appropriate Documentation [Section I.4.A.ii]

(a) description of incentive arrangements

(ii) time period of arrangement

Not applicable

(iii) enrollees, services, and providers covered

Not applicable

(iv) purpose

Not applicable

(v) confirmation that incentive payments will not exceed 105% of capitation payments

Not applicable

(vi) description of any effect on capitation rates

Not applicable

Withhold Arrangements [Section I.4.B]

Withhold Arrangements – Rate Development Standards [Section I.4.B.i]

(a) description of withhold arrangement

Not applicable.

(i) targets distinct from general operational requirements

Not applicable.

(ii) withhold penalty for noncompliance of operational requirements

Not applicable.

(b) actuarial soundness of capitation payment(s) minus any withhold that is not reasonably achievable

Not applicable.

Withhold Arrangements – Appropriate Documentation [Section I.4.B.ii]

(a) description of the withhold arrangement

(i) the time period of the withhold arrangement

Not applicable.

(ii) the enrollees, services, and providers covered by the withhold arrangement

Not applicable.

(iii) the purpose of the withhold arrangement

Not applicable.

(iv) description of the total percentage of the certified capitation rates being withheld through withhold arrangements.

Not applicable.

(v) estimate of the percentage of the withheld amount in a withhold arrangement that is not reasonably achievable and the basis for that determination

Not applicable.

(vi) a description of how the total withhold arrangement, achievable or not, is reasonable and takes into consideration the health plan's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the health plan's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves.

Not applicable.

(vii) a description of any effect that the withhold arrangements have on the development of the capitation rates.

Not applicable.

(b) Actuarial soundness of capitation payment(s) minus any withhold that is not reasonably achievable

Not applicable.

Risk-Sharing Mechanisms [Section I.4.C]

Risk Mitigation – Rate Development Standards [Section I.4.C.i]

(a) Risk-sharing mechanisms in the MCO contracts

The DBA contract does not contain any risk mitigation arrangements outside of the minimum MLR provision outlined in 42 CFR §438.8.

(b) Potential affect to final net payments to the MCOs

Not applicable.

Risk Mitigation – Appropriate Documentation [Section I.4.C.ii]

(a) Description of risk-sharing mechanisms other than minimum MLR or reinsurance

(i) The rationale for use of the risk sharing arrangement

Not applicable.

(ii) A detailed description of implementation

Not applicable.

(iii) A description of the effect of the risk-sharing arrangement on the development of capitation rates

Not applicable.

(iv) Documentation of compliance

Not applicable.

(b) MLR risk-sharing arrangement:

MCNA is subject to a settlement after each state fiscal year depending on its medical loss ratio (MLR). The MLR is calculated and reported consistently with 42 CFR 438.8(c).

If the MLR is lower than 85%, then MCNA shall remit 100% of the difference in total applicable revenue to achieve an 85% MLR. This risk-sharing mechanism mitigates the risk to the state of claims being lower than expected, as experienced during the COVID-19 public health emergency.

(c) Reinsurance requirements.

There are no reinsurance requirements in place.

Delivery System and Provider Payment Initiatives [Section I.4.D]

Not applicable.

Pass-Through Payments [Section I.4.E]

Not applicable.

PROJECTED NON-BENEFIT COSTS [SECTION I.5]

Non-Benefit Cost – Rate Development Standards [Section I.5.A]

See section I.5.B.

Non-Benefit Cost – Appropriate Documentation [Section I.5.B]

Description of non-benefit cost projection [Section I.5.B.i]:

MCNA's contract with the state specifies that the administrative load cannot exceed 15% of premium. We have assumed a load of 12.5% of revenue for the SFY 2021 rates. This is consistent with the SFY 2020 rates assumption. The SFY 2021 load of 12.5% reflects historical administrative expenses reported by MCNA and a provision for 1.5% of risk margin.

We have compared this administrative load to actual administrative costs as filed by MCNA, as well as loads added to capitation rates in other state Medicaid programs. These comparisons indicate that the 12.5% load is reasonable.

There is no load for state premium tax. The Idaho Department of Insurance has applied a 4 cent PMPM tax on this program, which we consider included in the 12.5% of premium retention load.

Categories of non-benefit costs [Section I.5.B.ii]:

Table 10 illustrates the projected non-benefit costs by category of costs.

TABLE 10: NON-BENEFIT COSTS AS A % OF PREMIUM

COMPONENT	CY 2018 ACTUAL	CY 2019 ACTUAL	SFY 2021 RATES
Administrative Costs	10.2%	9.4%	11.0%
Contribution to reserves/risk margin			1.5%
Sum of components			12.5%

Historical non-benefit cost data [Section 1.5.B.iii]:

See Table 10 above.

Health Insurance Providers Fee [Section I.5.B.iv]:

(a) how the fee is incorporated into capitation rates

The Health Insurance Providers Fee (HIPF) is not included in the capitation rates presented with this report.

(b) if the fee is incorporated into the rates in the initial rate certification, an explanation of whether the amount included in the rates is based on the data year or fee year during the rating period of the rate certification

Not applicable.

(c) description of how the fee was determined, and whether or not any adjustments would be made to the rates once the actual amount of the fee is known

Not applicable.

(d) if the fee is not incorporated into the rates in the rate certification because the rates will be adjusted to account for the fee subsequently, an explicit statement that the fee is not included, and a description of when and how the rates will ultimately be adjusted to account for the fee

The HIPF has been repealed for years after fee year 2020 and so these rates will not be adjusted to account for it.

(e) if the capitation rates include benefits as described in 26 CFR §57.2(h)(2)(ix) (e.g., long-term care, nursing home care, home health care, or community-based care), CMS recommends that the per member per month cost associated with those benefits be explicitly reported as a separate amount in the rate certification in order to more accurately account for the appropriate revenue on which the plans will be assessed

Not applicable.

(f) for managed care plans that were required to pay the fee in 2014, 2015, 2016,and/or 2018, a description as to whether or not the fee has been included in the capitation rates for those years (either prospectively in the rates or through amendments to the initially certified rates)

MCNA was required to pay the fee in 2018, and prior to that did not operate in Idaho. The HIF has never been included in prospective capitation rates for Idaho dental.

RISK ADJUSTMENT AND ACUITY ADJUSTMENTS [SECTION I.6]

Rate Development Standards [Section I.6.A]

These rates do not contain risk adjustment or acuity adjustment factors.

Appropriate Documentation [Section I.6.B]

Not applicable.

Medicaid Managed Care Rates with Long-Term Services and Supports [Section II]

Not applicable.

New Adult Group Capitation Rates [Section III]

DATA [SECTION III.1]

Description of data used [Section III.1.A]:

See sections I.1.B.i.(a) and I.2.B.iii. The base data used for Expansion rates was the same as for the legacy adult population.

Prior Expansion rates [Section III.1.B]:

New data [Section III.1.B.i]:

Idaho expanded Medicaid under the Affordable Care Act (ACA) effective January 1, 2020. Emerging experience from January and February 2020 was used to develop these rates.

Cost monitoring [Section III.1.B.ii]:

We have developed the rates using the most recent and complete data available.

Retrospective analysis [Section III.1.B.iii]:

Not applicable

Adjustments due to retrospective analysis [Section III.1.B.iv]:

No actual-to-expected adjustment was made.

PROJECTED BENEFIT COSTS [SECTION III.2]

Summary of assumptions [Section III.2.A]:

For states that covered the new adult group in previous rating periods [Section III.2.A.i]:

(a) Data used:

See section I.1.B.i.(a).

(b) Changes in data sources:

There have been no changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last rate certification.

The following data sources were used in the development of the Expansion rates:

- High-level anecdotal information from other states that have previously expanded
- Preannouncement factors from the Milliman Dental HCGs
- Emerging MCNA experience from January and February 2020

Based on our review of these data, we did not see a consistent pattern of differences in acuity between Expansion adults and legacy Medicaid adults in a stable market. We did observe a pattern of pent-up demand in the year of expansion.

(c) Changes to assumptions:

(i) Acuity or health status adjustments

There are no acuity or health status adjustments that apply specifically to the Expansion rates.

(ii) Pent-up demand:

Our evaluation of pent-up demand included the following sources:

- High-level and anecdotal review of experience from other states
- Review of impact to utilization in initial Expansion months due to COVID-19
- Review of standard commercial rating benchmarks from the Milliman *Health Cost Guidelines - Dental* (Dental HCGs)

This review indicated that an adjustment for pent-up demand was appropriate. Due to COVID-19, initial pent-up demand was not fully realized in the first six months of the program. We believe some pent-up demand will be

delayed and continue into SFY 2021, with higher utilization relative to the Adult rate cell. The adjustment selected is from the Dental HCGs.

The Dental HCGs represent a conglomeration of data, research and actuarial judgement, and provide a flexible but consistent basis for the determination of claim costs for a wide variety of dental benefit plans. Included in the Dental HCGs are a range of dental rating factors for dental utilization and costs, as well as considerations for how to select point estimates from these ranges based from an array of circumstances. Though the Dental HCGs are developed for commercial dental rating structures, in the absence of more applicable Idaho Medicaid data, we assumed that similar secular trends would impact commercial and Medicaid markets.

The Dental HCGs include factors related to the pre-announcement of a dental benefit in an employer group setting that reflect the increased demand for services following the addition of a dental benefit. These factors vary by the pre-announcement period (how much time between the announcement and the benefit effective date) and the incurred year of services (different factors for the first year and second year of services). We selected the "no pre-announcement" factors to reflect the difficulty of enrolling a Medicaid population relative to a commercial employer group. We have taken the average of the first-year and second-year factors in the "no pre-announcement" category to reflect the time period of these rates relative to January 1, 2020.

These factors, shown in Table 11, were applied by class of service to legacy adult data to project the level of pent-up demand expected in Expansion. The assumption for unclassified services was based on the composite factor, and the factor for FQHC encounters (D9999 service code) was based on the underlying distribution of services within those encounters.

TABLE 11: DENTAL HCG PRE-ANNOUNCEMENT FACTORS

CATEGORY OF SERVICE	FACTOR
Class I	1.055
Class II	1.150
Class III	1.235
Class IV	1.000
Unclassified	1.093
Composite	1.111

(iii) Adverse selection:

We did not make an explicit adjustment for adverse selection due to limited data available. We expect that the lack of member costs would reduce the potential for adverse selection. It is our implicit assumption that the Dental HCG factor described above includes provision for adverse selection.

(iv) Demographics:

There are no demographic adjustments that apply specifically to the Expansion rates.

(v) Delivery system differences:

There are no delivery system adjustments that apply specifically to the Expansion rates.

(vi) Other:

There are no other adjustments that apply specifically to the Expansion rates.

(vii) Changes to the benefit plan:

There are no changes to the benefit plan that apply specifically to the Expansion rates.

For states that did not cover the new adult group in previous rating periods [Section III.2.A.ii]:

Not applicable.

Key assumptions related to the new adult group [Section III.2.A.iii]:

See section III.2.A.i

Key assumptions to include [Section III.2.B]:

See section II.2.A

PROJECTED NON-BENEFIT COSTS [SECTION III.3]

New adult non-benefit costs [Section III.3.A]

See section I.5

Comparison to other populations [Section III.3.B]:

See section I.5

FINAL CERTIFIED RATES [SECTION III.4]

Comparison to prior rates [Section III.4.A.i]:

See Appendix A.

Description of other material changes [Section III.4.A.ii]:

All material changes are described elsewhere in this report.

RISK MITIGATION STRATEGIES [SECTION III.5]

Description of risk mitigation strategy [Section III.5.A]:

Not applicable

Additional risk mitigation information [Section III.5.B]:

There are no additional risk mitigation strategies specific to the Expansion population in the SFY 2021 rates.

Data Reliance and Caveats

We have modeled total costs in a managed care environment based on prior managed care data. The managed care assumptions implicit in these rates may not be realized.

This analysis is intended for the use of the State of Idaho Department of Health and Welfare (DHW) in support of the Medicaid managed care dental programs. No portion may be relied upon by any other party without Milliman's prior written consent. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for DHW by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of the DBA to make an independent determination as to the adequacy of the proposed capitation rates for their organization.

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis.

This analysis has relied extensively on data provided by DHW and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Milliman has developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by DHW for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

The models, including all input, calculations, and output may not be appropriate for any other purpose.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

The terms of Milliman's contract with the Idaho Department of Health and Welfare, effective July 1, 2019, apply to this report and its use.

Actuarial Certification

I, Benjamin Diederich, am a consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Idaho Department of Health and Welfare (DHW) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for the state's managed care program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the twelve-month period of state fiscal year (SFY) 2021.

To the best of my information, knowledge and belief, for the SFY 2021 period, the capitation rates offered by DHW are actuarially sound and comply with the requirements of 42 CFR § 438.4 and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the State of Idaho and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

The capitation rates developed herein may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DHW. The health plan may require rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

12/18/2020

Benjamin Diederich, FSA, MAAA,
Consulting Actuary

Date

APPENDIX A

Appendix A
State of Idaho
Department of Health and Welfare
SFY 2021 Dental Rate Development
DBA-submitted claims data incurred July 2018 to June 2019; paid through February 2020

Rate Cell	Experience MMs	Projected MMs	Projected Benefit Cost PMPM	COVID-19 Adjustment	Adjusted Benefit Cost PMPM	Administrative Cost	Projected SFY 2021 Rate PMPM	Projected Loss Ratio	SFY 2020 Rate (Net of Withhold)	Rate Change
Adult	872,518	890,774	$ 14.88	0.870	$ 12.95	$ 1.85	$ 14.80	87.5%	$ 16.35	(9.5%)
Expansion	0	1,034,213	16.53	0.870	14.38	2.05	16.43	87.5%	14.55	13.0%
Children - Basic	2,074,901	1,926,521	17.04	0.935	15.93	2.28	18.20	87.5%	18.44	(1.3%)
Children - Enhanced	336,527	307,899	18.23	0.850	15.50	2.21	17.71	87.5%	20.23	(12.5%)
Composite	3,283,946	4,159,407	$ 16.54	0.899	$ 14.87	$ 2.12	$ 17.00	87.5%	$ 17.16	(0.9%)

APPENDIX B

Appendix B-1
State of Idaho
Department of Health and Welfare
SFY 2021 Dental Rate Development
DBA-submitted claims data incurred July 2018 to June 2019; paid through February 2020

Age Group: Adult
Benefit Package: Combined

SFY 2019 Member Months 872,518
SFY 2021 Projected Member Months 890,774

Covered Class & Service Category	SFY 2019 Data Util./ 1000	SFY 2019 Data Avg Cost Service	SFY 2019 Data Paid PMPM	Adjustment Factors Fee Sch	Trend Util.	Trend Cost	SFY 2021 Cost Projection Util./ 1000	SFY 2021 Cost Projection Avg Cost Service	SFY 2021 Cost Projection Paid PMPM	Expansion Rate Projection Pent-up Demand Factor	Expansion Rate Projection Proj PMPM
Class I											
Oral Evaluations	207.3	$25.17	$0.43	1.000	1.061	1.000	219.9	$25.17	$0.46	1.055	$0.49
X-Rays	285.4	21.43	0.51	1.000	1.061	1.000	302.8	21.43	0.54	1.055	0.57
Lab and Other Tests	0.0	-	-	1.000	1.061	1.000	0.0	-	-	1.055	-
Prophylaxis	132.3	41.62	0.46	1.000	1.061	1.000	140.4	41.62	0.49	1.055	0.51
Fluoride	32.4	13.54	0.04	1.000	1.061	1.000	34.4	13.54	0.04	1.055	0.04
Sealants	0.0	-	-	1.000	1.061	1.000	0.0	-	-	1.055	-
Subtotal	**657.5**	**$26.28**	**$1.44**	**1.000**	**1.061**	**1.000**	**697.6**	**$26.28**	**$1.53**	1.055	**$1.61**
Class II											
Space Maintainers	0.0	$0.00	$0.00	1.000	1.030	1.000	0.0	$0.00	$0.00	1.150	$0.00
Restorations	294.0	57.65	1.41	1.347	1.030	1.000	302.8	77.64	1.96	1.150	2.25
Endodontics	1.6	49.61	0.01	1.000	1.030	1.000	1.6	49.61	0.01	1.150	0.01
Periodontics	54.7	59.26	0.27	1.000	1.030	1.000	56.4	59.26	0.28	1.150	0.32
Emergency (Palliative)	0.9	34.73	0.00	1.000	1.030	1.000	1.0	34.73	0.00	1.150	0.00
Anesthesia	32.8	43.55	0.12	1.300	1.030	1.000	33.8	56.61	0.16	1.150	0.18
Simple Extractions	152.8	59.17	0.75	1.300	1.030	1.000	157.4	76.90	1.01	1.150	1.16
Surgical Extractions	128.2	87.04	0.93	1.242	1.030	1.000	132.1	108.06	1.19	1.150	1.37
Oral Surgery	0.4	66.70	0.00	1.000	1.030	1.000	0.4	66.70	0.00	1.150	0.00
Subtotal	**665.4**	**$63.05**	**$3.50**	**1.279**	**1.030**	**1.000**	**685.5**	**$80.65**	**$4.61**	1.150	**$5.30**
Class III											
Inlays/Onlays/Crowns	0.0	$0.00	$0.00	1.000	0.990	1.000	0.0	$0.00	$0.00	1.235	$0.00
Repair (Simple)	1.4	35.76	0.00	1.000	0.990	1.000	1.4	35.76	0.00	1.235	0.01
Dentures	51.4	432.94	1.85	1.097	0.990	1.000	50.9	474.75	2.01	1.235	2.49
Other Prosthetics	1.8	23.08	0.00	1.000	0.990	1.000	1.8	23.08	0.00	1.235	0.00
Bridges	0.0	-	-	1.000	0.990	1.000	0.0	-	-	1.235	-
Subtotal	**54.6**	**$409.02**	**$1.86**	**1.096**	**0.990**	**1.000**	**54.1**	**$448.36**	**$2.02**	1.235	**$2.50**
Class IV											
Orthodontics	0.0	$0.00	$0.00	1.000	1.024	1.000	0.0	$0.00	$0.00	1.000	$0.00
Subtotal	**0.0**	**$0.00**	**$0.00**	**1.000**	**1.024**	**1.000**	**0.0**	**$0.00**	**$0.00**	1.000	**$0.00**
Other											
D9999 Encounter	327.4	$229.58	$6.26	1.000	1.024	1.000	335.3	$229.58	$6.41	1.093	$7.01
Unclassified	34.1	30.54	0.09	1.171	1.024	1.000	34.9	35.77	0.10	1.093	$0.11
Subtotal	**361.4**	**$210.83**	**$6.35**	**1.002**	**1.024**	**1.000**	**370.1**	**$211.32**	**$6.52**	1.093	**$7.12**
Grand Total	**1,738.9**	**$90.73**	**$13.15**				**1,807.3**	**$98.80**	**$14.88**	1.111	**$16.53**

Appendix B-2
State of Idaho
Department of Health and Welfare
SFY 2021 Dental Rate Development
DBA-submitted claims data incurred July 2018 to June 2019; paid through February 2020

Age Group:	**Child**	**SFY 2019 Member Months**	2,074,901
Benefit Package:	**Basic**	**SFY 2021 Projected Member Months**	1,926,521

	SFY 2019 Data			Adjustment Factors			SFY 2021 Cost Projection		
					Trend				
Covered Class & Service Category	**Util./ 1000**	**Avg Cost Service**	**Paid PMPM**	**Fee Sch**	**Util.**	**Cost**	**Util./ 1000**	**Avg Cost Service**	**Paid PMPM**
Class I									
Oral Evaluations	842.8	$21.52	$1.51	1.000	1.061	1.000	894.1	$21.52	$1.60
X-Rays	1,604.6	14.03	1.88	1.000	1.061	1.000	1,702.3	14.03	1.99
Lab and Other Tests	0.9	10.20	0.00	1.000	1.061	1.000	1.0	10.20	0.00
Prophylaxis	739.7	32.73	2.02	1.000	1.061	1.000	784.8	32.73	2.14
Fluoride	740.1	13.46	0.83	1.000	1.061	1.000	785.2	13.46	0.88
Sealants	606.4	20.76	1.05	1.000	1.061	1.000	643.4	20.76	1.11
Subtotal	**4,534.5**	**$19.28**	**$7.28**	**1.000**	**1.061**	**1.000**	**4,810.7**	**$19.28**	**$7.73**
Class II									
Space Maintainers	11.1	$99.21	$0.09	1.000	1.030	1.000	11.5	$99.21	$0.09
Restorations	504.9	51.86	2.18	1.282	1.030	1.000	520.1	66.46	2.88
Endodontics	50.9	89.41	0.38	1.000	1.030	1.000	52.5	89.41	0.39
Periodontics	1.1	64.50	0.01	1.000	1.030	1.000	1.1	64.50	0.01
Emergency (Palliative)	0.2	34.73	0.00	1.000	1.030	1.000	0.2	34.73	0.00
Anesthesia	29.3	48.20	0.12	1.300	1.030	1.000	30.2	62.66	0.16
Simple Extractions	96.9	44.06	0.36	1.225	1.030	1.000	99.8	53.99	0.45
Surgical Extractions	32.5	135.90	0.37	1.024	1.030	1.000	33.5	139.20	0.39
Oral Surgery	1.5	96.39	0.01	1.000	1.030	1.000	1.5	96.39	0.01
Subtotal	**728.3**	**$57.88**	**$3.51**	**1.210**	**1.030**	**1.000**	**750.3**	**$70.05**	**$4.38**
Class III									
Inlays/Onlays/Crowns	182.3	$93.90	$1.43	1.150	0.990	1.000	180.5	$107.99	$1.62
Repair (Simple)	2.1	30.33	0.01	1.000	0.990	1.000	2.0	30.33	0.01
Dentures	0.1	342.32	0.00	1.000	0.990	1.000	0.1	342.32	0.00
Other Prosthetics	0.0	40.19	0.00	1.000	0.990	1.000	0.0	40.19	0.00
Bridges	0.0	-	-	1.000	0.990	1.000	0.0	-	-
Subtotal	**184.5**	**$93.30**	**$1.43**	**1.149**	**0.990**	**1.000**	**182.6**	**$107.22**	**$1.63**
Class IV									
Orthodontics	24.8	$111.82	$0.23	1.000	1.024	1.000	25.4	$111.82	$0.24
Subtotal	**24.8**	**$111.82**	**$0.23**	**1.000**	**1.024**	**1.000**	**25.4**	**$111.82**	**$0.24**
Other									
D9999 Encounter	104.3	$248.38	$2.16	1.000	1.024	1.000	106.8	$248.38	$2.21
Unclassified	216.2	28.17	0.51	1.203	1.024	1.000	221.4	33.90	0.63
Subtotal	**320.5**	**$99.83**	**$2.67**	**1.039**	**1.024**	**1.000**	**328.2**	**$103.69**	**$2.84**
Grand Total	**5,792.6**	**$31.34**	**$15.13**				**6,097.2**	**$33.53**	**$17.04**

Appendix B-3
State of Idaho
Department of Health and Welfare
SFY 2021 Dental Rate Development
DBA-submitted claims data incurred July 2018 to June 2019; paid through February 2020

Age Group:	**Child**	**SFY 2019 Member Months**	336,527
Benefit Package:	**Enhanced**	**SFY 2021 Projected Member Months**	307,899

	SFY 2019 Data			Adjustment Factors			SFY 2021 Cost Projection		
					Trend				
Covered Class & Service Category	**Util./ 1000**	**Avg Cost Service**	**Paid PMPM**	**Fee Sch**	**Util.**	**Cost**	**Util./ 1000**	**Avg Cost Service**	**Paid PMPM**
Class I									
Oral Evaluations	803.1	$21.26	$1.42	1.000	1.061	1.000	852.0	$21.26	$1.51
X-Rays	1,434.5	15.76	1.88	1.000	1.061	1.000	1,521.9	15.76	2.00
Lab and Other Tests	0.1	10.20	0.00	1.000	1.061	1.000	0.1	10.20	0.00
Prophylaxis	697.3	35.49	2.06	1.000	1.061	1.000	739.8	35.49	2.19
Fluoride	673.2	13.50	0.76	1.000	1.061	1.000	714.2	13.50	0.80
Sealants	695.6	20.77	1.20	1.000	1.061	1.000	737.9	20.77	1.28
Subtotal	**4,303.8**	**$20.44**	**$7.33**	**1.000**	**1.061**	**1.000**	**4,565.9**	**$20.44**	**$7.78**
Class II									
Space Maintainers	7.7	$102.69	$0.07	1.000	1.030	1.000	7.9	$102.69	$0.07
Restorations	587.8	52.24	2.56	1.276	1.030	1.000	605.6	66.66	3.36
Endodontics	28.1	159.40	0.37	1.000	1.030	1.000	28.9	159.40	0.38
Periodontics	4.0	63.21	0.02	1.000	1.030	1.000	4.2	63.21	0.02
Emergency (Palliative)	0.2	34.73	0.00	1.000	1.030	1.000	0.3	34.73	0.00
Anesthesia	48.3	45.67	0.18	1.300	1.030	1.000	49.7	59.37	0.25
Simple Extractions	96.7	44.14	0.36	1.224	1.030	1.000	99.6	54.03	0.45
Surgical Extractions	75.7	136.27	0.86	1.029	1.030	1.000	78.0	140.22	0.91
Oral Surgery	1.6	87.39	0.01	1.000	1.030	1.000	1.7	87.39	0.01
Subtotal	**850.2**	**$62.54**	**$4.43**	**1.195**	**1.030**	**1.000**	**875.9**	**$74.76**	**$5.46**
Class III									
Inlays/Onlays/Crowns	89.9	$109.29	$0.82	1.150	0.990	1.000	89.0	$125.68	$0.93
Repair (Simple)	1.9	30.66	0.00	1.000	0.990	1.000	1.9	30.66	0.00
Dentures	0.1	292.71	0.00	1.000	0.990	1.000	0.1	292.71	0.00
Other Prosthetics	0.0	100.22	0.00	1.000	0.990	1.000	0.0	100.22	0.00
Bridges	0.0	-	-	1.000	0.990	1.000	0.0	-	-
Subtotal	**92.0**	**$107.89**	**$0.83**	**1.149**	**0.990**	**1.000**	**91.0**	**$123.92**	**$0.94**
Class IV									
Orthodontics	54.4	$126.76	$0.57	1.000	1.024	1.000	55.7	$126.76	$0.59
Subtotal	**54.4**	**$126.76**	**$0.57**	**1.000**	**1.024**	**1.000**	**55.7**	**$126.76**	**$0.59**
Other									
D9999 Encounter	130.5	$239.79	$2.61	1.000	1.024	1.000	133.7	$239.79	$2.67
Unclassified	194.0	28.79	0.47	1.204	1.024	1.000	198.7	34.67	0.57
Subtotal	**324.5**	**$113.65**	**$3.07**	**1.031**	**1.024**	**1.000**	**332.4**	**$117.16**	**$3.24**
Grand Total	**5,624.8**	**$34.64**	**$16.24**				**5,920.8**	**$36.95**	**$18.23**

APPENDIX C

Milliman

CMS Checklist Response
Capitated Contracts Rate Setting

Subsection AA.1 – General

AA.1.0 Overview of Ratesetting Methodology

The following is a high-level description of the approach used to develop actuarially sound dental capitation rates for the Idaho Department of Health and Welfare (DHW). The contract period for the capitation rates is state fiscal year (SFY) 2021 (July 1, 2020 through June 30, 2021). The contracting dental benefit administrator (DBA) is assuming full risk for all covered state plan dental services for enrolled members.

Critical steps in the rate development process included the following:

- Managed Care of North America (MCNA), the contracted DBA, provided detailed historical claim experience.
- DHW provided detailed historical eligibility data for covered Medicaid clients.
- The experience was adjusted to reflect the services covered for each group. Any non-covered expenses were removed from the base data.
- The cost projections included adjustments for trend, fee schedule changes, Expansion pent-up demand, COVID-19, and health plan non-benefit costs.

The rate setting steps are described in greater detail throughout the remainder of this document.

AA.1.1 ***Actuarial Certification***

This document is an appendix to the actuarial certification.

AA.1.2 ***Projection of Expenditures***

Our estimate of projected total costs for the contract period of SFY 2021, which covers 12 months of payments, is $70.7 million. See Table 3 in Section I.1.B.ii of the certification for estimated State and Federal expenditures by aid category.

AA.1.3 ***Procurement, Prior Approval and Ratesetting***

The method employed by the State in contracting with MCNA is the method listed in the *Financial Review Documentation for At-Risk Capitated Contracts Rate Setting* as Option 2: Competitive Procurement.

AA.1.5 ***Risk Contracts***

The assumption of full risk for the cost of services covered under the contract is specified in the contract.

AA.1.6 ***Limit on Payment to Other Providers***

The State of Idaho makes no payments to providers other than the contracted entity for the services covered under the contract.

AA.1.7 *Rate Modifications*

These rates are not a rate amendment or an update to a prior certification

Subsection AA.2 – Base Year Utilization and Cost Data

AA.2.0 *Base Year Utilization and Cost Data*

Milliman has relied on claims provided by MCNA and eligibility data provided by DHW for the experience period, SFY 2019 (July 1, 2018 through June 30, 2019). This data is specific to the population eligible for enrollment in the managed care program.

Utilization data

Utilization data are appropriate to the Medicaid population, as described above.

Service Cost

Service cost assumptions are appropriate to the Medicaid population, as described above.

AA.2.1 *Medicaid Eligibles under the Contract*

The base year of data includes only Medicaid eligible members.

AA.2.2 *Dual Eligibles (DE)*

Dual eligibles are enrolled in the dental managed care program if they meet other eligibility requirements.

AA.2.3 *Spenddown*

Spenddown eligibles are not enrolled in the dental managed care program.

AA.2.4 *State Plan Services Only*

No services outside the state plan are included in the rate development. This includes in lieu of services, which are not included in the rate development. Only covered dental services have been included in the analysis.

AA.2.5 *Services that may be Covered by a Capitated Entity out of Contract Savings*

No services outside the state plan are included in the rate development. Additional services outside of the state plan are provided by the current capitated entity out of contract savings, but these will be determined independent of the rate setting process.

Subsection AA.3 – Adjustments to the Base Year Data

AA.3.0 *Adjustments to the Base Year Data*

Different covered services are allowed for different populations in the contract period, as was the case during the experience period. We restricted the claims data to only the covered benefits shown in the Idaho Smiles Medicaid Dental Program Participant Handbook.

AA.3.1 *Benefit Differences*

There are no benefit differences anticipated between the base year and the contract year.

AA.3.2 Administrative Cost Allowance Calculations

See Section I.5.B.i of the certification.

AA.3.3 *Special Populations' Adjustments*

No adjustments were made to the data for special populations.

AA.3.4 *Eligibility Adjustments*

There are no material changes in the eligible population from the data collection period to the current point in time for non-Expansion rate cells. Effective January 1, 2020, Expansion members became eligible for Medicaid, which did not require adjustments to historical eligibility data.

AA.3.5 *DSH Payments*

No funding for DSH payments is included in the capitation rate development.

AA.3.6 *Third Party Liability (TPL)*

The DBA will act as the State's agent to collect TPL for all enrolled Medicaid recipients. The DBA's capitated payments have been computed based on claim experience that is net of these collections. The vendor is instructed to vigorously pursue billing prior resources as these amounts are considered part of their capitation.

AA.3.7 *Copayments, Coinsurance and Deductibles in Capitated Rates*

The program includes no member copayments, coinsurance or deductibles.

AA.3.8 *Graduate Medical Education (GME)*

No GME payments are included in the historical experience data or in the proposed capitation rates.

AA.3.9 *FQHC and RHC reimbursement*

The State has confirmed that the DBA is to comply with the FQHC/RHC payment requirements as described in the contract.

AA.3.10 *Medical Cost/Trend Inflation*

See Section I.3.B.iii of the certification.

AA.3.11 *Utilization Adjustments*

See Section I.3.B.iii of the certification.

AA.3.12 *Utilization and Cost Assumptions*

See Section I.3.B.iii of the certification.

AA.3.13 *Post-Eligibility Treatment of Income (PETI)*

Per the State of Idaho, PETI is not applicable to this program.

AA.3.14 *Incomplete Data Adjustment*

All data were considered complete. See Section I.2.B.ii of the certification.

Subsection AA.4 – Establish Rate Category Groupings

AA.4.0 *Establish Rate Category Groupings*

The State of Idaho has four rate cells: Adults, Expansion, Children - Basic, and Children - Enhanced. The Expansion (New Adult Group / VIII Group) population category is being included for the first time, since they will receive coverage effective January 1, 2020.

AA.4.1 *Age*

No age adjustment factors beyond child and adult rate groupings were applied. Rates are negotiated separately for each rate cell.

AA.4.2 *Gender*

No gender adjustment factors are planned at this time as the program is mandatory, operated through a single vendor and covers a specific population.

AA.4.3 *Locality/Region*

No locality/region adjustment factors are planned at this time. The program is mandatory, statewide and covers a specific population.

AA.4.4 *Eligibility Categories*

We have divided the eligibles into four rate cells:

- Adult
- Expansion
- Children - Basic
- Children - Enhanced

Section AA.5 – Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0 *Data Smoothing*

No data smoothing efforts were required in the rate development process.

AA.5.1 *Special Populations and Assessment of the Data for Distortions*

N/A

AA.5.2 *Cost-neutral Data Smoothing Adjustment*

N/A

AA5.3 *Risk-Adjustment*

Risk adjustment is not appropriate for this program.

Subsection AA.6 – Stop Loss, Reinsurance, or Risk-sharing Arrangements

AA.6.0 *Stop Loss, Reinsurance, or Risk-sharing Arrangements*

See Section I.4.C of the certification.

AA.6.1 *Commercial Reinsurance*

N/A

AA.6.2 *Simple Stop Loss Program*

N/A

AA.6.3 *Risk Corridor Program*

N/A

Subsection AA.7 – Incentive Arrangements

AA.7.0 *Incentive Arrangements*

N/A

Attachment 5 - 20200526 MMCP and IMPlus Rate Certification

Calendar Year 2020 Capitation Rate Development:

Medicaid Rates for Dual Eligible Clients Enrolled in Medicare-Medicaid Coordinated Plan (MMCP) and Idaho Medicaid Plus (IMPlus) Programs
State of Idaho

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Idaho Department of Health and Welfare

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Appendices

M1. EXECUTIVE SUMMARY

INTRODUCTION

The Idaho Department of Health and Welfare (DHW) retained Milliman, Inc. (Milliman) to develop actuarially sound Medicare-Medicaid Coordinated plan (MMCP) and Idaho Medicaid Plus (IMPlus) rates. This report outlines the data, assumptions, and methodology used in the calendar year (CY) 2020 capitation rate development for the enrolled dual Medicare and Medicaid members.

This report is intended to support and includes the actuarial certifications for both programs. Because the data, assumptions, and methodology for the MMCP and IMPlus programs are so similar, the narrative addresses both programs to facilitate ease of review and highlight areas where there are differences. As the contracts are separate for each of these programs we have created two separate certifications within the report.

On an annual basis, Milliman completes an analysis of the actuarial soundness of rates for the dual eligible enrollees covered under MMCP and IMPlus. The covered services considered for rate development are aligned within two major service categories: Long Term Services and Supports (LTSS) and medical, including behavioral health and pharmacy. Blue Cross of Idaho (BCI) and Molina are the two participating MMCP and IMPlus managed care organizations (vendors).

Rates are set separately for each managed care organization and program. However, the overall program structures are the same, with the primary difference being mandatory or voluntary enrollment. Eligible clients can be enrolled in one program or the other, but not both. Due to not all Idaho counties being covered by these programs not all dual Medicare and Medicaid eligible clients participate in the programs and so there are services for eligible members that are also provided under fee-for-service or other managed care arrangements. Note that enrollment in the MMCP and the IMPlus programs will result in disenrollment from the State's managed care behavioral health program.

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2019-2020 Medicaid Managed Care Rate Development Guide (CMS Guide), published March 2019:

> The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
>
> The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
>
> The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

CMS Guide Index [Section I.1.B]

We indexed each section of this report to the corresponding section of the "2019-2020 Medicaid Managed Care Rate Development Guide". For example, the contents within the brackets above refer to Section I, subsection 1 "General Information", bullet B "Appropriate Documentation". This notation appears in the table of contents as well as the body of this rate certification.

CAPITATION RATES

The monthly capitation rates for the contract period of January 1, 2020 – December 31, 2020 are $1,307.72 for BCI and $1,304.62 for Molina for the MMCP program and $1,400.03 for BCI and $1,399.65 for Molina for the IMPlus program. These rates represent increases from the prior rates paid due to medical trend and changes in the underlying enrollment mix assumptions for the rating period.

Both the current CY 2020 rates and the prior CY 2019 rates for BCI and Molina are summarized in the Table 1a (MMCP) and Table 1b (IMPlus), below.

Table 1a
Idaho Department of Health and Welfare
Medicare Medicaid Coordinated Plan (MMCP)
Summary of Rate Changes

Carrier	CY19 Certified Rate*	CY20 Certified Rate	Rate Change	% Change
BCI	$1,253.70	$1,307.72	$54.02	4.3%
Molina	$1,253.82	$1,304.62	$50.80	4.1%

**CY19 initial certified rate before adjustments for actual mix and MLR.*

Table 1b
Idaho Department of Health and Welfare
Idaho Medicaid Plus (IMPlus)
Summary of Rate Changes

Carrier	CY19 Certified Rate*	CY20 Certified Rate	Rate Change	% Change
BCI	$1,348.27	$1,400.03	$51.76	3.8%
Molina	$1,348.27	$1,399.65	$51.37	3.8%

**CY19 initial certified rate before adjustments for actual mix and MLR.*

As discussed in further detail below, the final rates will be adjusted in arrears in order to reflect the actual member mix enrolled for the year and settle to a Medical Loss Ratio (MLR) that lies within the +/- 3% corridor of the 88% target.

APPENDICES

Appendix A details the development of the rates.

M2. MEDICAID MANAGED CARE RATES [SECTION I]

GENERAL INFORMATION [SECTION I.1]

Rate Development Standards [Section I.1.A]

Rating Period [Section I.1.A.i]:

This rate certifications are for a 12-month rating period effective January 2020 to December 2020.

Items included in an acceptable rate certification [Section I.1.A.ii]:

a. *A letter from the certifying actuary:*

See Section M6 and M7 for the rate certifications at the end of this report.

b. *The final and certified capitation rates for all rate cells:*

The final and certified rates eligible for federal financial participation can be found in Tables 1a and 1b.

Appendix A steps through the adjustments to reach a final capitation payment for each rate cell.

- State Fiscal Year (SFY) 2018 fee-for-service data provided by DHW was summarized for all counties by rate cell and limited to covered services and eligible populations.
- The following adjustments are applied to project these claim costs to CY 2020:
  - Adjustment for annual utilization and unit cost trends to CY 2020.
  - Adjustment to reflect relativities of covered counties compared to statewide experience.
- A quality improvement (QI) load is applied.
- A non-benefit expense load (net of QI) is applied.

Additional information regarding the development of the CY 2020 MMCP and IMPlus rates is detailed in this report.

c. *Descriptions of the program:*

Table 2 shows the key components of each program:

Table 2
Idaho Department of Health and Welfare
MMCP and IMPlus
Comparison of Key Program Components

	MMCP	IMPlus
Enrollment	Voluntary	Mandatory if not in MMCP (counties with only one vendor are passive enrollment)
Population	Dual Adults, including DD waiver	Dual Adults, excluding DD waiver
Health Plan Vendors	BCI (original) Molina (added January 2018)	BCI & Molina (both effective October 2018)
Medicare coverage requirement	Beneficiary also enrolled in Medicaid health plan's Medicare Advantage plan	N/A
Covered Services	Medical + LTSS, described in data section below	Medical + LTSS, same as MMCP as of 1/1/2019
Counties Covered	30 – BCI 21 – Molina	30 – BCI* 21 – Molina* *Covered as of 4/1/2020
Rate Cell Blending	Retrospectively adjusted for actual enrollment mix	Retrospectively adjusted for actual enrollment mix
MLR settlement	88% target +/- 3%	88% target +/- 3%

The details surrounding the MMCP and IMPlus programs are expanded upon below.

(i) A summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

(A) The types and numbers of managed care plans included in the rate development:

For this program, the state is currently served by two managed care providers (BCI and Molina).

Some counties are not covered by these programs and are still covered primarily by Medicaid fee-for-service (FFS), with some behavioral health services covered through the managed care program with Optum.

(B) A general description or list of the benefits that are required to be provided by the managed care plan or plans:

The covered services considered for rate development fall within two major service categories: LTSS and medical. The covered services, which are parts of the state plan, are the same for all members in the MMCP and IMPlus programs.

LTSS services include home and community-based services for individuals with physical disabilities and individuals over age 65, in addition to institutional services in long-term care facilities. Medical services include physical health, behavioral health, and prescription drugs. All covered services are consistent with those provided through Medicaid FFS program and the State Plan.

(C) The areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

Since inception, MMCP has been a voluntary program that covers dual Medicare and Medicaid eligible enrollees. Prior to July 2014, the MMCP program existed in a different form, requiring enrollment within a Medicare Advantage plan, and covering fewer services, consisting of mostly Medicare cost sharing and some other state plan medical services and excluding LTSS.

In July 2014, the current form of MMCP rolled out with the inclusion of LTSS. Since the initial rollout, there have been only small changes to the program's covered services. BCI was the only vendor.

In January 2018, Molina joined the MMCP program as a second vendor.

In October 2018, the state also began offering a mandatory program, IMPlus, which is similar in design and structure to the MMCP program. Eligible members in covered counties who do not voluntarily enroll in the MMCP program are automatically enrolled into the IMPlus program.

By April 2020, MMCP and IMPlus will both cover 30 counties in Idaho, with both BCI and Molina covering 21 counties. IMPlus will use passive enrollment in the nine counties where only one vendor offers coverage.

Please see Appendix B for the full list of covered counties.

(ii) Rating period:

The rating period covered by this rate certification is CY 2020.

(iii) Covered populations:

Only the dual adult population is covered under these programs. The DD waiver population (identified by secondary aid code) will not be enrolled in IMPlus (while they can choose to enroll in MMCP).

Note that since these rates only cover dual Medicare and Medicaid members, the Medicaid expansion that occurred in Idaho in January 2020 is not adding additional members to these programs.

(iv) Eligibility and enrollment criteria:

Enrollment in the managed care plan is voluntary for the covered population in covered counties for the MMCP program. Eligible members in covered counties who do not voluntarily enroll in the MMCP program are automatically enrolled into the IMPlus program.

(v) Special contract provisions:

Not applicable.

(vi) Retroactive Adjustments:

There are no adjustments in the rate development for retrospective eligibility periods. Milliman receives all claims and eligibility information with sufficient lag to reflect all eligibility determinations. When processing the data, we match eligible members with the claims included in the base period used in the rate development

Differences between covered populations [Section I.1.A.iii]:

Any differences among capitation rates according to covered populations are based on valid rate development standards (such as differences in historical experience) and are not based on the rate of federal financial participation associated with the covered populations.

Cross-subsidization [Section I.1.A.iv]:

Capitation rates were developed such that payments from any rate cell do not cross-subsidize payments from any other rate cell. Note that there is only one certified rate for each program and vendor, as we've taken the blended approach. Projected rates by individual rate cells are blended based on the expected membership over the contract period to calculate the composite rate. Over the course of the contract, the composite payment rate for the program will be adjusted annually for the mix within the individual rate cells.

Consistency of effective dates [Section I.1.A.v]:

The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, and payment rate requirements) are consistent with the assumptions used to develop the capitation rates. These changes have been summarized in Section M1. Executive Summary, with detail included within the assumption documentation sections.

Considerations for MLR standards [Section I.1.A.vi]:

Capitation rates have been developed in such a way that each vendor and each program would reasonably achieve a medical loss ratio, as calculated under 42 CFR §438.8, of at least 85 percent for the rate year. In addition, as described in further detail below, the programs include a retrospective MLR settlement arrangement with a minimum MLR equal to 85 percent.

Considerations for CMS [Section I.1.A.vii]: *As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:*

a. *all adjustments are reasonable, appropriate, and attainable in the actuary's judgment.*

   All adjustments applied during the capitation rate development have been documented herein and are certified as part of the overall rates as reasonable, appropriate, and attainable by the certifying actuary.

b. *adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.*

   We have not made additional adjustments outside the rate setting process documented herein.

c. *consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell.*

   It is our understanding that the final contracted rates paid to the managed care entities for each eligible enrolled in each program (before the retrospective adjustment for actual member mix) are consistent with the capitation rates included in Table 1.

Certification period [Section I.1.A.viii]:

Rates are effective and certified for January 2020 through December 2020.

Procedures for rate certifications for rate and contract amendments [Section I.1.A.ix]:

Not applicable.

Appropriate Documentation [Section I.1.B]

Documentation detail required [Section I.1.B.i]: *States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:*

a. *Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources.*

The base claims data used to develop the capitation rates is a combination of historical FFS data plus behavioral health encounter data from state fiscal year (SFY) 2018 (July 1, 2017 – June 30, 2018), including run-out claims through March 2019.

Specifically, we relied on the following base data sources:

- Historical FFS data
  - Detailed claims data
    - Used for all LTSS categories of service
    - Used for most Medical categories of service (other than behavioral health)
  - Detailed eligibility data for both Medicaid-only and dual-eligible enrollees, including a flag indicating the enrollees' Medicaid-only or dual-eligible status, as well as secondary aid code.
- Encounter data provided by the state's behavioral health managed care organization (Optum)
  - We have included these managed care costs in our rate calculations since services Optum provides for the non-MMCP members are provided by BCI or Molina for the MMCP and IMPlus members. Behavioral health costs are the only services in the base period data that were provided under managed care.

The State of Idaho provided this data for all Medicaid enrollees, but the data considered for MMCP and IMPlus projections is restricted to those dual eligible enrollees in the FFS program that are eligible for the programs.

We determined that these sources of experience were a credible set of base data for all covered populations.

b. *Assumptions made:*

Details supporting all assumptions are provided throughout this document. The following adjustments have been applied during rate development:

- Restrict base claims data to only covered populations and services
- Adjust for claims incurred but not paid
- Unit cost and utilization trends from base period to CY 2020
- Area adjustment to reflect covered counties
- QI and Non-Benefit expenses

Methodology applied in developing assumptions and adjustments are described throughout this document where assumptions are identified.

Rate certification index [Section I.1.B.ii]

The table of contents of this document serves as the rate certification index.

Differences in FMAP [Section I.1.B.iii]

There are no rate development assumptions or methodologies that differ based on the rate of FMAP.

Managed care program additional documentation requests [Section I.1.B.iv]

a. *Comparison to previous certified rates*

The change in rates compared to the CY 2019 rates is shown in Table 1a and 1b.

b. *Description of any material changes to the rates or rate development process not addressed elsewhere*

Not applicable.

Data [Section I.2]

Rate Development Standards [Section 1.2.A]

Base data standards [Section I.2.A.i]:

a. *Validated data and audited financial reports*

The DHW provided validated data for use in rate development, from which we were able to identify the covered population, which was a starting point for this rate build. We have not audited or verified this data and other information, but we did compare data to historical data and control totals provided by the DHW for reasonableness. We also compared the Optum encounter data to the financial summaries they provided.

b. *Appropriate base data period*

We constructed rates using SFY 2018 claims data provided by the DHW, which was the most recent complete year of data available at the time of the analysis.

c. *Appropriate base data population*

We restricted the data from DHW to only include the dual beneficiaries covered under this certification and enrolled in the FFS program. During SFY 2018, IMPlus had not yet begun and only the voluntary MMCP program was in place. Thus, most dual eligibles were still covered under the FFS program, even though they are now eligibles for the MMCP and IMPlus programs.

Dual beneficiaries are identified based on a flag in the data and the Medicaid aid category code. Dual beneficiaries that would be eligible for premium assistance through Medicaid, but are not eligible for state plan services under Medicaid (Qualified Medicare Beneficiary, or QMB, and Specified Low Income Medicare Beneficiary or SLMB), are not considered within the MMCP and IMPlus rate projections. Members under the age of 21 are identified for exclusion (as they are not eligible for the programs). For IMPlus, eligibles with a secondary aid code identifying them as DD are also removed from the projection.

While duals already participating in MMCP in SFY 2018 are part of the covered population, for purposes of rate projection we have excluded this population. See the additional discussion in Section I.2.B.ii.c.ii below.

d. *Alternative data sources*

Not applicable.

Appropriate Documentation [Section I.2.B]

Description of data requested [Section I.2.B.i]: *In accordance with 42 CFR §438.7(b)(1), the rate certification must include:*

a. *A description of base data requested by the actuary for the rate setting process, including:*

(i) A summary of the base data that was requested by the actuary.

FFS detailed claims and eligibility files were requested from DHW, along with behavioral health detailed claims, eligibility, capitation files, and financial reports.

(ii) A summary of the base data that was provided by the state.

All requested data was provided.

(iii) An explanation of why any base data requested was not provided by the state.

Not applicable.

Description of data used to develop rates [Section I.2.B.ii]: *The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including:*

a. *Description of the data.*

We utilized FFS data and managed care encounter data.

We used the SFY 2018 FFS and behavioral health encounter data for the base period.

We received all data related to the base population from the DHW. Some assumptions were developed using information based on prior ratesetting assumptions, program experience, our experiences with other states, and Milliman research.

There are no sub-capitated costs in the base experience period.

b. *Data availability and quality:*

(i) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:

(A) completeness of the data.

(B) accuracy of the data.

(C) consistency of the data across data sources.

We processed this baseline data through Milliman's Health Cost Guidelines (HCG) Grouper and summarized by detailed service categories. This processing includes checking for duplicates and checking for membership matches against the eligibility file, as well as checking of various other fields in the data. The HCG Grouper consolidates the claim details and assigns detailed service categories. The resulting summaries allow us to evaluate the data for reasonableness and compare to prior years' data and other data sources. For example, we compared the Optum encounter data to the financial summaries they also provided.

From the data, we were able to calculate historical utilization and unit cost values, as well as the resulting PMPM costs. These summaries allow us to evaluate the data for reasonableness and compare to prior years' data and other data sources. We were able to determine the data is complete, accurate, and consistent, and have no concerns about the data. Data was not provided with the ultimate run-out of claims, so an adjustment was made to complete the base data for claims incurred but not paid (divide by 0.998).

(ii) a summary of the actuary's assessment of the data.

As the certifying actuary, I have assessed the quality of available data to be sufficient for the purpose of developing projected capitation rates effective during the contract period for the covered population.

All data were reviewed at several levels by consultants, actuaries, and data analysts who have experience with Medicaid data. We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent.

We do note that when we restricted the base data provided by the state to include only the dual eligible members participating in FFS, roughly half of the member months for dual eligibles already participating in MMCP were not identified and removed. This was estimated to have a less than 1% impact on projected costs in the ratesetting process, which is within the range of movement we have historically seen accounted for in the retroactive settlement calculation. .

(iii) any other concerns that the actuary has over the availability or quality of the data.

Not applicable.

c. *Data appropriateness: a description of how the actuary determined what data was appropriate to use for the rating period, including:*

(i) if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.

Not applicable. Recent FFS claims and managed care encounter data for the covered populations was used.

(ii) if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.

Milliman also requested and the State provided encounter data and associated financial reports related to the experience for members enrolled in the MMCP and IMPlus programs. This claims data was excluded from the base claim data. Eligible enrollees in these programs were excluded in the base period

for both Medical and LTSS categories of service during their time of enrollment in the programs. However, we did review the encounter data provided by DHW and used it to inform a number of assumptions. Our initial analysis of this data did not identify any significant concerns or material defects. The population during the base period enrolled in the MMCP and IMPlus programs is a small subset of the overall eligible population (approximately 11% enrolled in MMCP for SFY 2018, 0% for IMPlus for SFY 2018). Additionally, the number of covered counties expanded significantly in CY 2020. Therefore, we chose to use the credible base claims data for members covered under FFS and use the encounter data to inform other assumptions in the projection.

d. *Reliance on a data book:*

Not applicable.

Description of data adjustments [Section I.2.B.iii]:

a. *Credibility:*

Not applicable.

b. *Completion factors:*

Data was provided with paid dates through March 2019, without the ultimate run-out of claims, so an adjustment was made to complete the base data for claims incurred but not paid. Completion factors were developed by service category, using the following groupings:

- Mental Health and Physical Health
- Long Term Care and Developmental Disability
- Prescription Drug

These factors were also applied based on incurred month. As a result, the overall IBNP factor varied by each rate cell grouping. For SFY 2018, the overall expected completion factor was approximately 0.998. We divided the paid amounts by that factor to gross up the base period claims to expected ultimate incurred claims.

c. *Data errors:*

Not applicable.

d. *Program changes:*

There were only a handful of program changes between SFY 2018 and CY 2020. However, the FFS data includes a number of services that were not covered by MMCP and IMPlus, even in SFY 2018.

Some claims from the original data we receive are removed from consideration in our projections at the direction of the State. Our understanding is that these services remain covered for beneficiaries for enrollees under another mutually exclusive program or waiver.

We adjusted the base year claims data by removing service categories that the MMCP and IMPlus programs do not cover.

The removed services are:

- Dental Services
- Hearing Exams
    - Based on Milliman's HCG Grouper assigned MR_Line = 'P45'
    - See Appendix C-1 for HCPC codes associated with this MR_Line
- Home Health
    - Based on Milliman's HCG Grouper assigned MR_Line = 'P82'
    - See Appendix C-2 for HCPC codes associated with this MR_Line
- Select DD lines, identified based on srcSpecialty code (for only members with a secondary aid code of '14')
    - C00304597 Chore Services
    - C00304639 Behavior Consultation/Crisis Management
    - C00304641 Contractor-Home Modifications
    - C00304643 Certified Family Home (CFH)
    - C00304647 Residential Habilitation Agency
    - C00304649 DD Case Management
    - C00304693 Developmental Disability Agency

  - C00304709 Children's Service Coordination
  - C00305195 Respite Care
  - C00305225 Supported Employment Services
  - C00305227 Supports Brokerage-FEA
  - C00304827 Agency Transportation
- Select transportation lines, identified based on srcSpecialty code (for all members except those with secondary aid code '15')
  - C00307106 Individual Transportation Provider
  - C00307104 Commercial Transportation
- School based services: srcSpecialty code 'C00304811'
- Service Coordination Crisis Assistance
  - HCPCS = 'H2011' and no modifier
  - We understand this is provided by the health plan as part of their non-benefit expense add-on
- Intermediate Care Facility
  - srcSpecialty = 'C00306255'
- Targeted services coordination
  - HCPCS = 'G9007' and no modifier
  - HCPCS = 'H2011' and Modifier = 'HM'
  - HCPCS = 'G9002' and no Modifier and secondary aid code of '14'
  - HCPCS = 'G9002' and Modifier = 'HM' and secondary aid code of '14'
- Behavioral Crisis Consultation
  - HCPCS = 'H2019'
- We include srcSpecialty 'C00304561' Audiologist, even if it would have been excluded by above logic

We adjusted the base period for these exclusions, rather than applying a reduction as a programmatic adjustment from the base period to the projection period, as the FFS program continues to cover these expenditures and most of these services have been excluded since the start of the programs.

There was only a single change in covered services for CY 2020 as compared to CY 2019 rate certification work. As of 1/1/2020, Crisis Center Services will be covered and payable under both the MMCP and IMPlus programs. Based on discussions with DHW, we understand this benefit is currently being provided by the Department of Behavioral Health (DBH), which provides services to all, regardless of insurance type. As a result, historical utilization for the population covered under MMCP and IMPlus is not available. Our understanding is that this service change is expected to have an immaterial impact on costs for the covered populations. We have applied a 1.0 adjustment factor to reflect this. All other benefit exclusions are reflected in the base period data, so no additional adjustments are needed to account for differences in covered services between the base period and projection period.

e. *Exclusions:*

Not applicable.

PROJECTED BENEFIT COSTS AND TRENDS [SECTION I.3]

Rate Development Standards [Section I.3.A]

Services in final rates [Section I.3.A.i]:

Final capitation rates are based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

Variations in assumptions [Section I.3.A.ii]:

Variations in the assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

Development of benefit cost trends [Section I.3.A.iii]:

See section I.3.B.iii.

In-lieu-of services [Section I.3.A.iv]:

Not applicable.

Costs associated with IMDs [Section I.3.A.v]:

Not applicable.

Appropriate Documentation [Section I.3.B]

Projected benefit costs [Section I.3.B.i]:

Appendix A shows the development of the projected benefit costs.

Development of projected benefit costs [Section I.3.B.ii]:

a. *Description of the data, assumptions and methodologies used to develop the projected benefit costs.*

We relied on data supplied by the DHW, conversations with the DHW, internal Milliman research and publicly available data sources to develop assumptions to adjust the base period data and produce projected benefit cost estimates.

For the rate development and projections, we have split the dual eligible Medicaid members into three main categories:

- Community Well,
- Home and Community Based Services (HCBS),
- and Institutional.

We also evaluate the costs separately for the two major service categories of LTSS and medical. Within each service category, we expand the population types to a slightly different level of granularity for the rate cell groupings. Lastly, due to operational constraints, the final rate is calculated as a composite of all rate cell level groupings, based on an assumed membership mix. Over the course of each contract year, the actual membership mix is re-evaluated retrospectively for comparison to the original assumptions. The revised composite rate for actual membership mix is then used within the MLR settlement calculation. Material changes in the membership mix will result in an update to the PMPM rate. The logic of member categorization used for rate development is consistent with the logic used for the program's retrospective MLR settlement. These groupings and service category splits are described in further detail below.

For the LTSS cost projections, we categorize members as Institutional Level of Care (ILOC) - Institutional in a particular month if they have had 21 or more days of nursing facility services within that month. Members who we do not categorize as institutional in a month are categorized as ILOC - HCBS if they have long-term care category of service claims (outside of nursing facility). We consider all other members to be Community Well. The Community Well category is further subdivided based on the member's age (21-44, 45-64, and 65+). Appendix D details the specific criteria used to identify these services.

When developing cost projections for medical services, we categorize members into rate cells using a different set of groupings. The ILOC medical rate cell category is composed of all members included in the ILOC - Institutional and ILOC – HCBS LTSS categories described above.

For the community well medical rate cell category, we developed additional eligibility indicators for Developmental Disability (DD) and Serious and Persistent Mental Illness (SPMI) populations. These flags are based on secondary aid codes and diagnosis code history of enrollees from medical enrollment, as described below.

Beginning with 2020 ratesetting, the DD Medical rate cell category is now identified based on the presence of secondary aid code '14' in the DHW eligibility file, which is how DHW identifies eligible enrollees covered by the DD waiver. Note that this is a change from the ratesetting approaches for 2019 and prior, where beneficiaries were identified as DD based on diagnosis codes in the medical claims data. This new way of identifying the DD population now aligns with DHW's identification of the DD population. Notably, since beneficiaries covered by the DD waiver are not mandatorily enrolled under the IMPlus program, this rate cell category is excluded from the IMPlus projections. A member flagged as both DD and SPMI is identified as DD.

The SPMI Medical rate cell category is also a condition-based category. Enrollees are identified as having an SPMI condition based on a listing of diagnosis codes. Once a member is identified as SPMI, they are flagged for the duration of their enrollment within Medicaid programs as long as they retain their Medicaid ID. DHW developed and produced the diagnosis codes use for identification of SPMI members. Note that for the identification of members with the SPMI condition in the MMCP program, we use the combined diagnosis code list for both children

with Serious Emotional Disturbance (SED) or the adults with SPMI conditions. While the SED list is included for completeness, it will likely have little impact on the MMCP rate cell assignment. Milliman has not performed any audits or review of the diagnosis code data used to identify members with this condition. These exhibits are included as Appendix D.

The remainder of the population is included in the Community Well Medical rate cell category.

See Section 1.3.B.iii for additional information regarding the data, assumptions and methodologies used to develop the projected benefit costs.

b. Material changes to the data, assumptions and methodologies since the last rate certification.

As noted above, members are now included in the DD Medical rate cell based on the presence of the DD secondary aid code in the eligibility file.

c. The amount of overpayments to providers and a description of how the state accounted for this in rate development.

There are no known amounts of overpayments made to providers. The facilities providing services, including hospitals and skilled nursing facilities are paid at an interim rate, with a final rate or settlement being paid retrospectively. This is done since Idaho does not have a DRG-based payment system, and allows for the final reimbursement to providers to be made based on the final costs incurred for each facility. The FFS data we receive typically has the interim rate payments, thus does not account for the final amounts being paid to the facilities. We have not made any adjustments to our projections to account for this, as the final adjustment amount varies each year. Based on our understanding, we do not expect future payment rates to materially differ from the rates included in the base period. However, the final MLR settlement should allow for protection on both ends should that not be the case. The State will continue to pay the final settlement amounts.

Trends [Section I.3.B.iii]:

a. *This section must include:*

(i) Data and assumptions used to develop trends:

(A) Descriptions of data and assumptions.

Trend assumptions were applied on a per member per month (PMPM) basis. We developed a single PMPM trend rather than separate utilization and unit cost trends to increase the credibility of this adjustment. The following tables summarize the annual trend rates assumed in the analysis.

Table 3a
Idaho Department of Health and Welfare
Medicare Medicaid Coordinated Plan (MMCP)
Estimate of PMPM Trend Rates

Member Category	Trend Rate
ILOC	
ILOC - Institutional	2.7%
ILOC - HCBS	3.9%
ILOC - Community - Well (all ages)	0.0%
Medical	0.0%

Table 3b
Idaho Department of Health and Welfare
Idaho Medicaid Plus (IMPlus)
Estimate of PMPM Trend Rates

Member Category	Trend Rate
ILOC	
ILOC - Institutional	2.7%

ILOC - HCBS	4.5%
ILOC - Community - Well (all ages)	0.0%
Medical	0.0%

We selected these trend assumptions based primarily upon our review of historical Idaho Medicaid data from SFY 2016 – SFY 2018.

We applied the same annual trends for both BCI and Molina.

Based on our discussions with the State, there are no anticipated changes to the program level of unit cost or utilization that would require a change in annual trend.

(B) Reliance on experience

Historical program experience was the primary source used to develop our trend assumption, as described above.

(i) Methodologies used to develop trends:

We summarized the FFS and Optum encounter data for dual eligible members by state fiscal year and member category, limited to included services. Consistent with prior year projections, we believe that using four distinct trend rates produces the best overall trend assumptions, as we noticed some of the groups of rate cells had similar patterns of trends and were more credible on a combined basis. LTSS trends for each member category were set to the average annual historical trend from SFY 2016 – SFY 2018. We applied a 0% annualized Medical trend for all populations, as the historical trend summaries for all populations have been negative on average from SFY 2016 – SFY 2018. We do not expect the negative trends to persist.

(iii) Comparisons to historical trends:

Trends were set based on historical trends for covered members in the FFS program. In cases where historical trends have been negative, we have applied a 0% trend.

The tables below compare these trend assumptions to our prior trend assumptions included in our rate certifications for CY19 as well as the observed historical trends.

Table 4a
Idaho Department of Health and Welfare
Medicare Medicaid Coordinated Plan (MMCP)
Summary of PMPM Trend Rate Changes

Member Category	CY19 Trend Rate	Historical Trends	CY20 Trend Rate
ILOC			
ILOC - Institutional	2.7%	2.7%	2.7%
ILOC - HCBS	0.6%	3.9%	3.9%
ILOC - Community - Well (all ages)	1.8%	-1.7%	0.0%
Medical	0.0%	-3.0%	0.0%

Table 4b
Idaho Department of Health and Welfare
Idaho Medicaid Plus (IMPlus)
Summary of PMPM Trend Rate Changes

Member Category	CY19 Trend Rate	Historical Trends	CY20 Trend Rate
ILOC			
ILOC - Institutional	4.0%	2.7%	2.7%
ILOC - HCBS	0.3%	4.5%	4.5%
ILOC - Community - Well (all ages)	0.0%	-1.7%	0.0%
Medical	0.0%	-3.0%	0.0%

(iv) Outlier and negative trends:

Not applicable.

b. *Components of trend:*

As described above, trend is applied together for utilization and cost increases, as PMPM trends.

c. *Variations in trend:*

Trend assumptions vary by population based on variations in historical trend only.

d. *Other material adjustments to trend:*

Not applicable.

e. *Other non-material adjustments to trend:*

Not applicable.

Adjustments due to MHPAEA [Section I.3.B.iv]:

Not applicable.

In-lieu-of services [Section I.3.B.v]:

Not applicable.

Retrospective eligibility periods [Section I.3.B.vi]:

Not applicable.

Changes to covered benefits or services [Section I.3.B.vii]:

a. *More or fewer state plan benefits covered by Medicaid managed care.*

See Section I.2.B.iii.(d).

b. *Any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d).*

See Section I.3.B.ii.(c).

c. *Requirements related to payments from health plans to any providers or class of providers.*

See Section I. 4.D.

d. *Requirements or conditions of any applicable waivers.*

We are not aware of any new requirements that would be included as covered benefits under the managed care entity.

e. *Requirements of conditions of any litigation to which the state is subjected.*

We are not aware of any requirements or conditions of any litigation to which the state is subjected.

Impact of changes to covered benefits or services [Section I.3.B.viii]:

See section I.2.B.(iii).(d).

SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT [SECTION I.4]

Incentive Arrangements [Section I.4.A]

Rate Development Standards [Section I.4.A.i]

Not applicable.

Appropriate Documentation [Section I.4.A.ii]

Not applicable.

Withhold Arrangements [Section I.4.B]

Rate Development Standards [Section I.4.B.i]

Not applicable.

Appropriate Documentation [Section I.4.B.ii]

Not applicable.

Risk-Sharing Mechanisms [Section I.4.C]

Rate Development Standards [Section I.4.C.i]

See section 1.4.C.ii.

Appropriate Documentation [Section I.4.C.ii]

Consistent with prior years, the state pays each vendor a single composite rate for all enrolled members each month. The rate in the certification is the calculated composite rate across all rate cells, based on an assumed membership mix. The original assumption for membership mix is the information reflected in the rates in this certification. Retrospectively, on an annual basis at the time of the MLR settlement payment, we calculate an updated composite rate based on the actual membership mix. In determining the membership mix as a part of the settlement calculation, the member grouping is held each year at the assigned group set three months prior to the start of each contract period. We will use actual eligibility data and claims data and the same member categorization logic outlined above to determine this population group for each member. Therefore, material shifts in the membership mix during the contract period will result in an update to the vendor's PMPM rate. This is critical since there are two vendors and two programs. Therefore, the mix that enrolls may differ significantly from the originally assumed membership mix.

There will not be any type of diagnosis based risk adjustment.

In addition to the retrospective rate adjustment for membership mix, there is also a risk sharing arrangement in the form of an MLR Settlement. Retrospectively, The MLR settlement payment will include the component to update the composite rate as well as a settlement for the actual program experience. We use the updated composite rate in the loss ratio settlement calculation. The target MLR is 88% with a 3% corridor within which no adjustments will be made to the membership mix adjusted rates. If the MLR is lower than 85%, then the managed care organization shall remit 100% of the difference in total applicable revenue to achieve an 85% MLR. If the MLR is above 91%, the State of Idaho will remit to the managed care organization 100% of the difference in total applicable revenue to achieve a 91% MLR. These calculations will be done separately for each vendor, and separately for the MMCP and IMPlus programs.

Delivery System and Provider Payment Initiatives [Section I.4.D]

Rate Development Standards [Section I.4.D.i]

Not applicable.

Appropriate Documentation [Section I.4.D.ii]

Not applicable.

Pass-Through Payments [Section I.4.E]

Rate Development Standards [Section I.4.E.i]

Not applicable.

Appropriate Documentation [Section I.4.E.ii]

Not applicable.

PROJECTED NON-BENEFIT COSTS [SECTION I.5]

Rate Development Standards [Section I.5.A]

See Section I.5.B.

Appropriate Documentation [Section I.5.B]

Description of non-benefit cost projection [Section I.5.B.i]:

a. Description of data, assumptions and methodologies

Rates include a non-benefit expense load of approximately 9.4% of premium (excluding quality improvements). This load accounts for the administrative costs associated with a managed care program and margin.

The non-benefit expense load varies by ratecell, so the overall non-benefit expense load varies based on the assumed population mix. Most notably, the non-benefit load for the ILOC-Institutional rate cell is set as a lower percentage than all of the other LTSS rate-cells. The rate cell-specific percentages have all been scaled down slightly from the values included in the prior certification to reflect a lower risk margin for the vendors. The original amounts were based on the percentages originally bid by BCI. These percentages now range from 14.0% for most individual rate cells, down to 3.5% for the Institutional ("ILOC – Institutional") rate cell for LTSS. Based on the assumed membership mix and projected costs, the composite non-benefit expense loads for both vendors is approximately 9.4%. We also reviewed the actual historical non-benefit expenses summaries from BCI to validate this assumption. These loads account for the non-benefit costs associated with a managed care program, including administrative costs, taxes and fees, and risk margin. These loads are applied to the projected claims net of quality improvements.

Of the 9.4% non-benefit expense load, we assume 1% of it would be risk margin for the vendors (previously assumed to be 1.5%).

An additional load ($110 PMPM) has been added to the managed care rates to account for quality improvement expenditures. This additional amount is based on the actual BCI quality improvement expenditures during CY 2017, and has been proportionally allocated to each rate cell. The amount is consistent with the amount assumed in the CY 2019 certification. We relied greatly on BCI's reported experience and financial summaries for this quality improvement assumption. In discussions with BCI, it is our understanding that the methodology used to create their non-benefit and quality improvement summaries is the same methodology used to populate non-benefit expense for both the Medicare and Medicaid MLR reporting schedules. Discussions with both BCI and the state also helped shed light on this assumption and the goals surrounding the quality improvement activities. Because we had no expectations or similar situations to serve as a comparison basis, our main analysis consisted of validating the values in the BCI financial statement and confirming the included activities were in line with program goals. Quality improvement amounts from Molina were still being prepared and reviewed at the time these rates were developed. We note that in the MLR formula used for the retrospective settlement, the actual quality improvement activities are included and treated like benefit expenditures.

b. Material changes to the data, assumptions and methodologies since the last rate certification.

Not applicable.

c. Other material adjustments

Not applicable.

Categories of non-benefit costs [Section I.5.B.ii]:

See Section I.5.B.i.

Health Insurance Providers Fee [Section I.5.B.iii]:

The administrative allowance does not include for the costs of the Health Insurance Providers Fee (HIF). Our understanding is that the State will account for the Health Insurance Provider Fee retrospectively. BCI informed us that they are excluded from paying the Health Insurance Providers Fee, as they fall under the exception, per the guidance, that "more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act". In general, Molina does pay the Health Insurance Provider fee. Therefore, we plan to account for this fee retrospectively once any actual payment amounts are known. We note that the portion of the rate associated with LTSS is not subject to the Health Insurance Provider Fee. We anticipate making a retrospective adjustment for these CY 2020 rates for Molina when the payment amount is known.

RISK ADJUSTMENT AND ACUITY ADJUSTMENTS [SECTION I.6]

Rate Development Standards [Section I.6.A]

See Section I.6.B.

Appropriate Documentation [Section I.6.B]

Description of all prospective risk adjustment methodologies [Section I.6.B.i]:

Not applicable.

Description of all retrospective risk adjustment methodologies [Section I.6.B.ii]:

See Section I.4.C.ii.

Additional rate certification and supporting documentation requirements [Section I.6.B.iii]:

See Section I.4.C.ii.

Description of acuity adjustments [Section I.6.B.iv]:

The projections in Appendix A summarize the base experience and adjustments by member category. The exhibit separately summarizes the experience for LTSS and medical services. Both sections of both exhibits use a weighting based on the average SFY 2018 membership distribution for the non-MMCP/IMPlus dual-eligible population. The membership mix underlying the rate projections is different for BCI and Molina, based on the associated covered counties for CY 2020. Membership is scaled to the September 2019 enrollment for each program.

Additionally, an area adjustment is made because the programs are available to eligible dual Medicare and Medicaid enrollees in a mix of counties in Idaho. Since not all counties are covered by the MMCP and IMPlus programs, we applied area adjustments to the base period data to reflect area level differences in cost associated with the underlying county mix in each program. These adjustment factors were calculated by comparing the base period data costs for the covered counties versus all counties in the SFY 2018 FFS data. While the factors vary by sub-population, the overall composite area adjustment applied was approximately 0% for BCI and 1% for Molina in each of the programs, respectively.

The base year data of medical and LTSS services is a mix of managed care (behavioral health services) and FFS (all other services). To evaluate the need for a managed care savings adjustment, we looked at members who had been covered under the MMCP program and compared their historical experience under the MMCP program to their experience under FFS. Based on this review, we did not see evidence that supports a material adjustment factor for managed care savings. Therefore, we chose not to apply a reduction for managed care savings. We believe this is reasonable, as a material portion of the medical claims is already covered under managed care (behavioral health claims) and the savings for medical cost sharing in general would be dampened compared to the overall impact on total dollars. The LTSS management savings for the program overall are assumed to be derived from managing the mix of members by LTSS category, and additional savings will result over time as admissions into nursing facilities are delayed.

While the MMCP program is voluntary, there are no adjustments made for favorable or adverse selection. Due to the structure of the contract, a retrospective payment will be made if the enrolled population mix in both the MMCP and the IMPlus programs differs from the assumed population distribution.

M3. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS [SECTION II]

GENERAL INFORMATION [SECTION II.1]

Information Specific to MLTSS [Section II.1.A]

Please refer to Section I and note that all responses also apply to MLTSS, unless otherwise specified.

Rate Development Standards [Section II.1.B]

Rate cell structure [Section II.1.B.i]:

See Section II.1.C.i.

Appropriate Documentation [Section II.1.C]

MLTSS considerations [Section II.1.C.i]:

a. *The structure of the capitation rates and rate cells or rating categories*

   Rates are set using a blended structure, with one composite calculation rate paid for all enrollees. See Section I.4.C.ii for additional details.

b. *The structure of rates and the rate cells*

   Historical data is summarized and projected at the rate cell level, with the composite rate calculated based on the assumed membership mix (during rate setting) and actual membership mix (during retrospective review). See Section I.4.C.ii for additional details.

c. *Any other payment structures, incentives, or disincentives used*

   There are no other incentives beyond those described above.

d. *The expected effect that managing LTSS has on the utilization and unit costs of services*

   There are no modeled impacts.

e. *Any effect that the management of this care is expected to have within each care setting*

   There are no modeled impacts.

Non-benefit costs [Section II.1.C.ii]:

See section I.5.B.i.

Historical experience, Analysis, and Other Sources [Section II.1.C.ii]:

See Section I.1.B.i.

M4. NEW ADULT GROUP CAPITATION RATES [SECTION III]

Not applicable. The new expansion population is not included under this certification.

M5. DATA RELIANCE AND CAVEATS

This document and its attached exhibits, appendices and data are intended for use by the DHW in support of its CY 2020 MMCP and IMPlus capitation rates. This report may be shared with CMS for that purpose. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this presentation to other third parties. Similarly, third parties are instructed that they are to place no reliance upon this analysis prepared for the DHW by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. The terms of Milliman's contract with the DHW effective July 1, 2019 apply to this analysis and its use. Other parties receiving this report must rely upon their own experts in drawing conclusions about the data underlying the cost model. It is the responsibility of any insurance carrier to establish required revenue levels appropriate for their risk, management, and contractual obligations for the prospective population.

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual program experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis.

We have relied on data from numerous sources to compile this report. This report and associated analyses rely extensively on data provided by the DHW. These data include, among other items, eligibility, capitation payment records, and encounters for both mental health benefits. We have not audited or verified this data, though we have compared some of the data provided to us to financial summaries provided by the DHW in order to assess the reasonableness of the data. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review of the data to search for data values that are of questionable validity or for relationships which are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

M6. ACTUARIAL CERTIFICATION (MMCP)

I, Benjamin J. Diederich, am a consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Idaho Department of Health and Welfare (DHW) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for Idaho's managed care Medicare-Medicaid Coordinated plan program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the one year period of January 2020 to December 2020.

To the best of my information, knowledge and belief, for the January 2020 to December 2020 period, the capitation rates offered by the DHW are actuarially sound and comply with the requirements of 42 CFR § 438.4, the CMS Managed Care Rate Setting Guide and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on ACOs, MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the ACO, MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the DHW and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

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Benjamin J. Diederich, FSA, MAAA
Consulting Actuary

May 26, 2020

_____

Date

M7. ACTUARIAL CERTIFICATION (IDAHO MEDICAID PLUS)

I, Benjamin J. Diederich, am a consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Idaho Department of Health and Welfare (DHW) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for Idaho's managed care Idaho Medicaid Plus program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the one year period of January 2020 to December 2020.

To the best of my information, knowledge and belief, for the January 2020 to December 2020 period, the capitation rates offered by the DHW are actuarially sound and comply with the requirements of 42 CFR § 438.4, the CMS Managed Care Rate Setting Guide and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on ACOs, MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the ACO, MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the DHW and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

_____

Benjamin J. Diederich, FSA, MAAA
Consulting Actuary

May 26, 2020

_____

Date

Appendix A-1
CY 2020 Projection MMCP
Baseline Experience, Adjustments and Projected Rate Amounts
Blue Cross of Idaho

Baseline - LTSS SFY 2018[2]			Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM		Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Institutional	448	$5,504.88	1.027	$5,888.01	0.99	$5,812.13	$588.70	$6,400.84
ILOC - HCBS	1,319	$1,155.63	1.039	$1,272.21	1.00	$1,270.44	$123.59	$1,394.03
Community - Well 21-44	1,003	$48.43	1.000	$48.43	1.04	$50.14	$5.18	$55.31
Community - Well 45-64	1,205	$52.45	1.000	$52.45	1.06	$55.43	$5.61	$61.04
Community - Well 65+	1,301	$77.72	1.000	$77.72	1.02	$79.65	$8.31	$87.96
Composite	5,276	$796.87	1.012	$858.56	0.99	$853.15	$85.22	$938.37
Non-Benefit Percentage						8.0%	0.0%	7.3%
Total LTSS PMPM						$926.98	$85.22	$1,012.20

Baseline - Medical SFY 2018[2]			Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM		Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Medical	1,767	$291.28	1.000	$291.28	1.01	$294.69	$31.15	$325.84
DD - Medical	364	$126.01	1.000	$126.01	1.01	$127.56	$13.48	$141.03
SPMI - Medical	1,702	$263.14	1.000	$263.14	0.99	$259.54	$28.14	$287.68
Community - Well Medical	1,443	$148.38	1.000	$148.38	1.02	$151.93	$15.87	$167.80
Composite	5,276	$231.72	1.000	$231.72	1.00	$232.78	$24.78	$257.56
Non-Benefit Percentage						14.0%	0.0%	12.8%
Total Medical PMPM						$270.74	$24.78	$295.52
Total LTSS + Medical PMPM		$1,028.59		$1,090.28	1.00	$1,085.93	$110.00	$1,195.93
With Non-Benefit						$1,197.72		$1,307.72

Other Inputs	Years of Trend
	2.50

1 Average Members is distribution of Non-MMCP / Non-IMPlus SFY 2018 member months in covered counties.
2 Baseline - LTSS and Baseline - Medical are SFY 2018 Non-MMCP / Non-IMPlus data for dual members across all counties and restricted to only covered services.

Appendix A-2
CY 2020 Projection MMCP
Baseline Experience, Adjustments and Projected Rate Amounts
Molina

Baseline - LTSS SFY 2018[2]			Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM		Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Institutional	169	$5,504.88	1.027	$5,888.01	1.00	$5,905.51	$596.97	$6,502.47
ILOC - HCBS	521	$1,155.63	1.039	$1,272.21	0.99	$1,264.42	$125.32	$1,389.74
Community - Well 21-44	402	$48.43	1.000	$48.43	1.07	$51.68	$5.25	$56.93
Community - Well 45-64	470	$52.45	1.000	$52.45	1.10	$57.71	$5.69	$63.40
Community - Well 65+	503	$77.72	1.000	$77.72	1.09	$84.88	$8.43	$93.31
Composite	2,065	$782.67	1.012	$843.45	1.00	$846.49	$84.87	$931.37
Non-Benefit Percentage						8.0%	0.0%	7.4%
Total LTSS PMPM						$920.50	$84.87	$1,005.37

Baseline - Medical SFY 2018[2]			Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM		Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Medical	690	$291.28	1.000	$291.28	1.03	$299.33	$31.59	$330.92
DD - Medical	150	$126.01	1.000	$126.01	1.01	$127.46	$13.66	$141.13
SPMI - Medical	669	$263.14	1.000	$263.14	0.99	$259.48	$28.54	$288.01
Community - Well Medical	556	$148.38	1.000	$148.38	1.06	$157.27	$16.09	$173.36
Composite	2,065	$231.69	1.000	$231.69	1.02	$235.69	$25.13	$260.82
Non-Benefit Percentage						14.0%	0.0%	12.8%
Total Medical PMPM						$274.13	$25.13	$299.25
Total LTSS + Medical PMPM		$1,014.36		$1,075.14	1.01	$1,082.18	$110.00	$1,192.18
With Non-Benefit						$1,194.62		$1,304.62

Other Inputs	Years of Trend
	2.50

1 Average Members is distribution of Non-MMCP / Non-IMPlus SFY 2018 member months in covered counties.
2 Baseline - LTSS and Baseline - Medical are SFY 2018 Non-MMCP / Non-IMPlus data for dual members across all counties and restricted to only covered services.

Appendix A-3
CY 2020 Projection Idaho Medicaid Plus
Baseline Experience, Adjustments and Projected Rate Amounts
Blue Cross of Idaho

Baseline - LTSS SFY 2018[2]			Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM		Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Institutional	515	$5,505.75	1.027	$5,889.08	0.99	$5,823.47	$551.19	$6,374.66
ILOC - HCBS	1,480	$1,193.43	1.045	$1,331.60	1.00	$1,328.87	$119.48	$1,448.35
Community - Well 21-44	913	$61.76	1.000	$61.76	1.06	$65.20	$6.18	$71.39
Community - Well 45-64	1,265	$57.57	1.000	$57.57	1.08	$62.28	$5.76	$68.04
Community - Well 65+	1,476	$79.00	1.000	$79.00	1.06	$84.06	$7.91	$91.97
Composite	5,650	$858.51	1.014	$929.68	1.00	$925.91	$85.95	$1,011.86
Non-Benefit Percentage						8.0%	0.0%	7.4%
Total LTSS PMPM						$1,006.93	$85.95	$1,092.88

Baseline - Medical SFY 2018[2]			Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM		Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Medical	1,996	$294.05	1.000	$294.05	1.03	$301.47	$29.44	$330.91
DD - Medical	-	$0.00	1.000	$0.00	-	$0.00	$0.00	$0.00
SPMI - Medical	1,990	$263.14	1.000	$263.14	0.99	$259.54	$26.34	$285.89
Community - Well Medical	1,664	$148.38	1.000	$148.38	1.04	$153.98	$14.86	$168.83
Composite	5,650	$240.26	1.000	$240.26	1.01	$243.26	$24.05	$267.31
Non-Benefit Percentage						14.1%	0.0%	13.0%
Total Medical PMPM						$283.10	$24.05	$307.15
Total LTSS + Medical PMPM		$1,098.77		$1,169.94	1.00	$1,169.17	$110.00	$1,279.17
With Non-Benefit						$1,290.03		$1,400.03

Other Inputs	Years of Trend
	2.50

1 Average Members is distribution of Non-MMCP / Non-IMPlus SFY 2018 member months in covered counties.
2 Baseline - LTSS and Baseline - Medical are SFY 2018 Non-MMCP / Non-IMPlus data for dual members across all counties and restricted to only covered services.
3 The DD - Medical population is not covered under the IMPlus program.

Appendix 1-4
CY 2020 Projection Idaho Medicaid Plus
Baseline Experience, Adjustments and Projected Rate Amounts
Molina

Baseline - LTSS SFY 2018[2]			Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM		Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Institutional	456	$5,505.75	1.027	$5,889.08	1.00	$5,893.63	$555.99	$6,449.62
ILOC - HCBS	1,360	$1,193.43	1.045	$1,331.60	0.99	$1,322.62	$120.52	$1,443.14
Community - Well 21-44	843	$61.76	1.000	$61.76	1.09	$67.05	$6.24	$73.28
Community - Well 45-64	1,144	$57.57	1.000	$57.57	1.12	$64.43	$5.81	$70.24
Community - Well 65+	1,329	$79.00	1.000	$79.00	1.12	$88.16	$7.98	$96.14
Composite	5,132	$848.69	1.014	$919.34	1.00	$922.14	$85.70	$1,007.84
Non-Benefit Percentage						8.1%	0.0%	7.5%
Total LTSS PMPM						$1,003.52	$85.70	$1,089.23

Baseline - Medical SFY 2018[2]			Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM		Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Medical	1,815	$294.05	1.000	$294.05	1.04	$304.64	$29.69	$334.33
DD - Medical	-	$0.00	1.000	$0.00	-	$0.00	$0.00	$0.00
SPMI - Medical	1,820	$263.14	1.000	$263.14	0.99	$259.50	$26.57	$286.07
Community - Well Medical	1,497	$148.38	1.000	$148.38	1.06	$157.98	$14.98	$172.96
Composite	5,132	$240.60	1.000	$240.60	1.02	$245.85	$24.30	$270.15
Non-Benefit Percentage						14.1%	0.0%	13.0%
Total Medical PMPM						$286.13	$24.30	$310.42
Total LTSS + Medical PMPM		$1,089.29		$1,159.94	1.01	$1,167.99	$110.00	$1,277.99
With Non-Benefit						$1,289.65		$1,399.65

Other Inputs	Years of Trend
	2.50

1 Average Members is distribution of Non-MMCP / Non-IMPlus SFY 2018 member months in covered counties.
2 Baseline - LTSS and Baseline - Medical are SFY 2018 Non-MMCP / Non-IMPlus data for dual members across all counties and restricted to only covered services.
3 The DD - Medical population is not covered under the IMPlus program.

Appendix B
CY 2020 Summary
Medicare Medicaid Coordinated Plan (MMCP) and Idaho Medicaid Plus (IMPlus)
Covered Counties
Blue Cross of Idaho and Molina

	MMCP				IMPlus			
Counties (1)	**Previously Covered BCI**	**Previously Covered Molina**	**CY2020 Covered BCI**	**CY2020 Covered Molina**	**Previously Covered BCI**	**Previously Covered Molina**	**CY2020 Covered BCI (2)(3)**	**CY2020 Covered Molina (2)**
Ada	X	X	X	X	X	X	X	X
Adams			X				X	
Bannock	X	X	X	X	X	X	X	X
Benewah			X				X	
Bingham	X	X	X	X	X	X	X	X
Boise	X		X	X			X	X
Bonner	X	X	X	X	X	X	X	X
Bonneville	X	X	X	X	X	X	X	X
Boundary	X		X	X			X	X
Canyon	X	X	X	X	X	X	X	X
Cassia	X		X	X			X	X
Clark	X		X				X	
Elmore	X		X	X			X	X
Fremont	X		X	X			X	X
Gem	X		X	X			X	X
Gooding			X				X	
Jefferson	X		X	X			X	X
Jerome			X				X	
Kootenai	X	X	X	X	X	X	X	X
Latah			X				X	
Madison	X		X	X			X	X
Minidoka	X		X	X			X	X
Nez Perce	X	X	X	X	X	X	X	X
Owyhee	X		X	X			X	X
Payette	X		X	X			X	X
Power	X		X	X			X	X
Shoshone			X				X	
Twin Falls	X	X	X	X	X	X	X	X
Valley			X				X	
Washington			X				X	
Total Covered	22	9	30	21	9	9	30	21
Coverage	*22 of 44; 50%*	*9 of 44; 20%*	*30 of 44; 68%*	*21 of 44; 48%*	*9 of 44; 20%*	*9 of 44; 20%*	*30 of 44; 68%*	*21 of 44; 48%*

(1) Grayed out counties are not covered under either the MMCP or IMPlus programs
(2) Counties covered as of 4/1/2020
(3) Any Counties not covered by Molina are passive enrollment

Appendix C - 1
HCPCS Associated with Milliman Grouper Line Used to Identify excluded Hearing Exam claims

PROC		New PROC (1)	Retired PROC (1)
92550	92582	92521	92506
92551	92583	92522	92569
92552	92584	92523	92573
92553	92585	92524	92510
92555	92586	92558	92589
92556	92587	0208T	
92557	92588	0209T	
92559	92590	0210T	
92560	92591	0211T	
92561	92592	0212T	
92562	92593		
92563	92594		
92564	92595		
92565	92596		
92567	92597		
92568	S0618		
92570	S9152		
92571	V5008		
92572	V5010		
92575	V5299		
92576	V5362		
92577	V5363		
92579	V5364		

(1) Codes added or removed from Milliman grouper logic since latest list of procedure codes provided.

Appendix C - 2
HCPCS Associated with Milliman Grouper Line
Used to Identify excluded Home Health claims

PROC						New PROC (1)	Retired PROC (1)	
99500	1BHMV	2BFMV	3AHNV	3CHMV	4CHMV	G0068	G0154	HCEM2
99501	1BHMW	2BFMW	3AHNW	3CHMW	4CHMW	G0069	G0163	HCEM3
99502	1BHMX	2BFMX	3AHNX	3CHMX	4CHMX	G0070	G0164	HCEM4
99503	1BHN1	2BGK1	3AHP1	3CHN1	5AFK1	G0076	HAEJ1	HCEM5
99504	1BHN2	2BGK2	3AHP2	3CHN2	5AFK2	G0077	HAEJ2	HCEM6
99505	1BHN3	2BGK3	3AHP3	3CHN3	5AFK3	G0078	HAEJ3	HCEM7
99506	1BHN4	2BGK4	3AHP4	3CHN4	5AFK4	G0079	HAEJ4	HCEM8
99507	1BHN5	2BGK5	3AHP5	3CHN5	5AFK5	G0080	HAEJ5	HCFJ1
99509	1BHN6	2BGK6	3AHP6	3CHN6	5AFK6	G0081	HAEJ6	HCFJ2
99510	1BHNS	2BGKS	3AHPS	3CHNS	5AFKS	G0082	HAEJ7	HCFJ3
99511	1BHNT	2BGKT	3AHPT	3CHNT	5AFKT	G0083	HAEJ8	HCFJ4
99512	1BHNU	2BGKU	3AHPU	3CHNU	5AFKU	G0084	HAEK1	HCFJ5
99600	1BHNV	2BGKV	3AHPV	3CHNV	5AFKV	G0085	HAEK2	HCFJ6
99601	1BHNW	2BGKW	3AHPW	3CHNW	5AFKW	G0086	HAEK3	HCFJ7
99602	1BHNX	2BGKX	3AHPX	3CHNX	5AFKX	G0087	HAEK4	HCFJ8
1AFK1	1BHP1	2BGL1	3BFK1	3CHP1	5AGK1	G0299	HAEK5	HCFK1
1AFK2	1BHP2	2BGL2	3BFK2	3CHP2	5AGK2	G0300	HAEK6	HCFK2
1AFK3	1BHP3	2BGL3	3BFK3	3CHP3	5AGK3	G0490	HAEK7	HCFK3
1AFK4	1BHP4	2BGL4	3BFK4	3CHP4	5AGK4	G0493	HAEK8	HCFK4
1AFK5	1BHP5	2BGL5	3BFK5	3CHP5	5AGK5	G0494	HAEL1	HCFK5
1AFK6	1BHP6	2BGL6	3BFK6	3CHP6	5AGK6	G0495	HAEL2	HCFK6
1AFKS	1BHPS	2BGLS	3BFKS	3CHPS	5AGKS	G0496	HAEL3	HCFK7
1AFKT	1BHPT	2BGLT	3BFKT	3CHPT	5AGKT	G9473	HAEL4	HCFK8
1AFKU	1BHPU	2BGLU	3BFKU	3CHPU	5AGKU	G9474	HAEL5	HCFL1
1AFKV	1BHPV	2BGLV	3BFKV	3CHPV	5AGKV	G9475	HAEL6	HCFL2
1AFKW	1BHPW	2BGLW	3BFKW	3CHPW	5AGKW	G9476	HAEL7	HCFL3
1AFKX	1BHPX	2BGLX	3BFKX	3CHPX	5AGKX	G9477	HAEL8	HCFL4
1AFL1	1CFK1	2BGM1	3BFL1	4AFK1	5AHK1	G9478	HAEM1	HCFL5
1AFL2	1CFK2	2BGM2	3BFL2	4AFK2	5AHK2	G9479	HAEM2	HCFL6
1AFL3	1CFK3	2BGM3	3BFL3	4AFK3	5AHK3	G9490	HAEM3	HCFL7
1AFL4	1CFK4	2BGM4	3BFL4	4AFK4	5AHK4	Q2052	HAEM4	HCFL8
1AFL5	1CFK5	2BGM5	3BFL5	4AFK5	5AHK5	S9110	HAEM5	HCFM1
1AFL6	1CFK6	2BGM6	3BFL6	4AFK6	5AHK6	T1000	HAEM6	HCFM2
1AFLS	1CFKS	2BGMS	3BFLS	4AFKS	5AHKS	T1001	HAEM7	HCFM3
1AFLT	1CFKT	2BGMT	3BFLT	4AFKT	5AHKT	T1002	HAEM8	HCFM4
1AFLU	1CFKU	2BGMU	3BFLU	4AFKU	5AHKU	T1003	HAFJ1	HCFM5
1AFLV	1CFKV	2BGMV	3BFLV	4AFKV	5AHKV	T1004	HAFJ2	HCFM6
1AFLW	1CFKW	2BGMW	3BFLW	4AFKW	5AHKW	T1005	HAFJ3	HCFM7
1AFLX	1CFKX	2BGMX	3BFLX	4AFKX	5AHKX	T1021	HAFJ4	HCFM8
1AFM1	1CFL1	2BHK1	3BFM1	4AFL1	5BFK1	T1030	HAFJ5	HCGJ1
1AFM2	1CFL2	2BHK2	3BFM2	4AFL2	5BFK2	T1031	HAFJ6	HCGJ2
1AFM3	1CFL3	2BHK3	3BFM3	4AFL3	5BFK3	T2042	HAFJ7	HCGJ3
1AFM4	1CFL4	2BHK4	3BFM4	4AFL4	5BFK4	T2043	HAFJ8	HCGJ4
1AFM5	1CFL5	2BHK5	3BFM5	4AFL5	5BFK5	T2044	HAFK1	HCGJ5
1AFM6	1CFL6	2BHK6	3BFM6	4AFL6	5BFK6	T2045	HAFK2	HCGJ6
1AFMS	1CFLS	2BHKS	3BFMS	4AFLS	5BFKS	T2046	HAFK3	HCGJ7
1AFMT	1CFLT	2BHKT	3BFMT	4AFLT	5BFKT		HAFK4	HCGJ8
1AFMU	1CFLU	2BHKU	3BFMU	4AFLU	5BFKU		HAFK5	HCGK1
1AFMV	1CFLV	2BHKV	3BFMV	4AFLV	5BFKV		HAFK6	HCGK2
1AFMW	1CFLW	2BHKW	3BFMW	4AFLW	5BFKW		HAFK7	HCGK3
1AFMX	1CFLX	2BHKX	3BFMX	4AFLX	5BFKX		HAFK8	HCGK4
1AFN1	1CFM1	2BHL1	3BFN1	4AFM1	5BGK1		HAFL1	HCGK5
1AFN2	1CFM2	2BHL2	3BFN2	4AFM2	5BGK2		HAFL2	HCGK6
1AFN3	1CFM3	2BHL3	3BFN3	4AFM3	5BGK3		HAFL3	HCGK7
1AFN4	1CFM4	2BHL4	3BFN4	4AFM4	5BGK4		HAFL4	HCGK8
1AFN5	1CFM5	2BHL5	3BFN5	4AFM5	5BGK5		HAFL5	HCGL1
1AFN6	1CFM6	2BHL6	3BFN6	4AFM6	5BGK6		HAFL6	HCGL2
1AFNS	1CFMS	2BHLS	3BFNS	4AFMS	5BGKS		HAFL7	HCGL3
1AFNT	1CFMT	2BHLT	3BFNT	4AFMT	5BGKT		HAFL8	HCGL4
1AFNU	1CFMU	2BHLU	3BFNU	4AFMU	5BGKU		HAFM1	HCGL5
1AFNV	1CFMV	2BHLV	3BFNV	4AFMV	5BGKV		HAFM2	HCGL6
1AFNW	1CFMW	2BHLW	3BFNW	4AFMW	5BGKW		HAFM3	HCGL7
1AFNX	1CFMX	2BHLX	3BFNX	4AFMX	5BGKX		HAFM4	HCGL8
1AFP1	1CFN1	2BHM1	3BFP1	4AGK1	5BHK1		HAFM5	HCGM1
1AFP2	1CFN2	2BHM2	3BFP2	4AGK2	5BHK2		HAFM6	HCGM2
1AFP3	1CFN3	2BHM3	3BFP3	4AGK3	5BHK3		HAFM7	HCGM3
1AFP4	1CFN4	2BHM4	3BFP4	4AGK4	5BHK4		HAFM8	HCGM4

Appendix C - 2
HCPCS Associated with Milliman Grouper Line
Used to Identify excluded Home Health claims

PROC						New PROC (1)	Retired PROC (1)
1AFP5	1CFN5	2BHM5	3BFP5	4AGK5	5BHK5	HAGJ1	HCGM5
1AFP6	1CFN6	2BHM6	3BFP6	4AGK6	5BHK6	HAGJ2	HCGM6
1AFPS	1CFNS	2BHMS	3BFPS	4AGKS	5BHKS	HAGJ3	HCGM7
1AFPT	1CFNT	2BHMT	3BFPT	4AGKT	5BHKT	HAGJ4	HCGM8
1AFPU	1CFNU	2BHMU	3BFPU	4AGKU	5BHKU	HAGJ5	HCHJ1
1AFPV	1CFNV	2BHMV	3BFPV	4AGKV	5BHKV	HAGJ6	HCHJ2
1AFPW	1CFNW	2BHMW	3BFPW	4AGKW	5BHKW	HAGJ7	HCHJ3
1AFPX	1CFNX	2BHMX	3BFPX	4AGKX	5BHKX	HAGJ8	HCHJ4
1AGK1	1CFP1	2CFK1	3BGK1	4AGL1	5CFK1	HAGK1	HCHJ5
1AGK2	1CFP2	2CFK2	3BGK2	4AGL2	5CFK2	HAGK2	HCHJ6
1AGK3	1CFP3	2CFK3	3BGK3	4AGL3	5CFK3	HAGK3	HCHJ7
1AGK4	1CFP4	2CFK4	3BGK4	4AGL4	5CFK4	HAGK4	HCHJ8
1AGK5	1CFP5	2CFK5	3BGK5	4AGL5	5CFK5	HAGK5	HCHK1
1AGK6	1CFP6	2CFK6	3BGK6	4AGL6	5CFK6	HAGK6	HCHK2
1AGKS	1CFPS	2CFKS	3BGKS	4AGLS	5CFKS	HAGK7	HCHK3
1AGKT	1CFPT	2CFKT	3BGKT	4AGLT	5CFKT	HAGK8	HCHK4
1AGKU	1CFPU	2CFKU	3BGKU	4AGLU	5CFKU	HAGL1	HCHK5
1AGKV	1CFPV	2CFKV	3BGKV	4AGLV	5CFKV	HAGL2	HCHK6
1AGKW	1CFPW	2CFKW	3BGKW	4AGLW	5CFKW	HAGL3	HCHK7
1AGKX	1CFPX	2CFKX	3BGKX	4AGLX	5CFKX	HAGL4	HCHK8
1AGL1	1CGK1	2CFL1	3BGL1	4AGM1	5CGK1	HAGL5	HCHL1
1AGL2	1CGK2	2CFL2	3BGL2	4AGM2	5CGK2	HAGL6	HCHL2
1AGL3	1CGK3	2CFL3	3BGL3	4AGM3	5CGK3	HAGL7	HCHL3
1AGL4	1CGK4	2CFL4	3BGL4	4AGM4	5CGK4	HAGL8	HCHL4
1AGL5	1CGK5	2CFL5	3BGL5	4AGM5	5CGK5	HAGM1	HCHL5
1AGL6	1CGK6	2CFL6	3BGL6	4AGM6	5CGK6	HAGM2	HCHL6
1AGLS	1CGKS	2CFLS	3BGLS	4AGMS	5CGKS	HAGM3	HCHL7
1AGLT	1CGKT	2CFLT	3BGLT	4AGMT	5CGKT	HAGM4	HCHL8
1AGLU	1CGKU	2CFLU	3BGLU	4AGMU	5CGKU	HAGM5	HCHM1
1AGLV	1CGKV	2CFLV	3BGLV	4AGMV	5CGKV	HAGM6	HCHM2
1AGLW	1CGKW	2CFLW	3BGLW	4AGMW	5CGKW	HAGM7	HCHM3
1AGLX	1CGKX	2CFLX	3BGLX	4AGMX	5CGKX	HAGM8	HCHM4
1AGM1	1CGL1	2CFM1	3BGM1	4AHK1	5CHK1	HAHJ1	HCHM5
1AGM2	1CGL2	2CFM2	3BGM2	4AHK2	5CHK2	HAHJ2	HCHM6
1AGM3	1CGL3	2CFM3	3BGM3	4AHK3	5CHK3	HAHJ3	HCHM7
1AGM4	1CGL4	2CFM4	3BGM4	4AHK4	5CHK4	HAHJ4	HCHM8
1AGM5	1CGL5	2CFM5	3BGM5	4AHK5	5CHK5	HAHJ5	HCIJ1
1AGM6	1CGL6	2CFM6	3BGM6	4AHK6	5CHK6	HAHJ6	HCIJ2
1AGMS	1CGLS	2CFMS	3BGMS	4AHKS	5CHKS	HAHJ7	HCIJ3
1AGMT	1CGLT	2CFMT	3BGMT	4AHKT	5CHKT	HAHJ8	HCIJ4
1AGMU	1CGLU	2CFMU	3BGMU	4AHKU	5CHKU	HAHK1	HCIJ5
1AGMV	1CGLV	2CFMV	3BGMV	4AHKV	5CHKV	HAHK2	HCIJ6
1AGMW	1CGLW	2CFMW	3BGMW	4AHKW	5CHKW	HAHK3	HCIJ7
1AGMX	1CGLX	2CFMX	3BGMX	4AHKX	5CHKX	HAHK4	HCIJ8
1AGN1	1CGM1	2CGK1	3BGN1	4AHL1	G0151	HAHK5	HCIK1
1AGN2	1CGM2	2CGK2	3BGN2	4AHL2	G0152	HAHK6	HCIK2
1AGN3	1CGM3	2CGK3	3BGN3	4AHL3	G0153	HAHK7	HCIK3
1AGN4	1CGM4	2CGK4	3BGN4	4AHL4	G0155	HAHK8	HCIK4
1AGN5	1CGM5	2CGK5	3BGN5	4AHL5	G0156	HAHL1	HCIK5
1AGN6	1CGM6	2CGK6	3BGN6	4AHL6	G0157	HAHL2	HCIK6
1AGNS	1CGMS	2CGKS	3BGNS	4AHLS	G0158	HAHL3	HCIK7
1AGNT	1CGMT	2CGKT	3BGNT	4AHLT	G0159	HAHL4	HCIK8
1AGNU	1CGMU	2CGKU	3BGNU	4AHLU	G0160	HAHL5	HCIL1
1AGNV	1CGMV	2CGKV	3BGNV	4AHLV	G0161	HAHL6	HCIL2
1AGNW	1CGMW	2CGKW	3BGNW	4AHLW	G0162	HAHL7	HCIL3
1AGNX	1CGMX	2CGKX	3BGNX	4AHLX	Q5001	HAHL8	HCIL4
1AGP1	1CGN1	2CGL1	3BGP1	4AHM1	Q5003	HAHM1	HCIL5
1AGP2	1CGN2	2CGL2	3BGP2	4AHM2	Q5004	HAHM2	HCIL6
1AGP3	1CGN3	2CGL3	3BGP3	4AHM3	Q5005	HAHM3	HCIL7
1AGP4	1CGN4	2CGL4	3BGP4	4AHM4	Q5006	HAHM4	HCIL8
1AGP5	1CGN5	2CGL5	3BGP5	4AHM5	Q5007	HAHM5	HCIM1
1AGP6	1CGN6	2CGL6	3BGP6	4AHM6	Q5008	HAHM6	HCIM2
1AGPS	1CGNS	2CGLS	3BGPS	4AHMS	Q5009	HAHM7	HCIM3
1AGPT	1CGNT	2CGLT	3BGPT	4AHMT	Q5010	HAHM8	HCIM4
1AGPU	1CGNU	2CGLU	3BGPU	4AHMU	S0270	HAIJ1	HCIM5
1AGPV	1CGNV	2CGLV	3BGPV	4AHMV	S0271	HAIJ2	HCIM6
1AGPW	1CGNW	2CGLW	3BGPW	4AHMW	S0272	HAIJ3	HCIM7

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HCPCS Associated with Milliman Grouper Line
Used to Identify excluded Home Health claims

PROC						New PROC (1)	Retired PROC (1)
1AGPX	1CGNX	2CGLX	3BGPX	4AHMX	S5035	HAIJ4	HCIM8
1AHK1	1CGP1	2CGM1	3BHK1	4BFK1	S5036	HAIJ5	HDEJ1
1AHK2	1CGP2	2CGM2	3BHK2	4BFK2	S5100	HAIJ6	HDEJ2
1AHK3	1CGP3	2CGM3	3BHK3	4BFK3	S5101	HAIJ7	HDEJ3
1AHK4	1CGP4	2CGM4	3BHK4	4BFK4	S5102	HAIJ8	HDEJ4
1AHK5	1CGP5	2CGM5	3BHK5	4BFK5	S5105	HAIK1	HDEJ5
1AHK6	1CGP6	2CGM6	3BHK6	4BFK6	S5108	HAIK2	HDEJ6
1AHKS	1CGPS	2CGMS	3BHKS	4BFKS	S5109	HAIK3	HDEJ7
1AHKT	1CGPT	2CGMT	3BHKT	4BFKT	S5110	HAIK4	HDEJ8
1AHKU	1CGPU	2CGMU	3BHKU	4BFKU	S5111	HAIK5	HDEK1
1AHKV	1CGPV	2CGMV	3BHKV	4BFKV	S5115	HAIK6	HDEK2
1AHKW	1CGPW	2CGMW	3BHKW	4BFKW	S5116	HAIK7	HDEK3
1AHKX	1CGPX	2CGMX	3BHKX	4BFKX	S5120	HAIK8	HDEK4
1AHL1	1CHK1	2CHK1	3BHL1	4BFL1	S5121	HAIL1	HDEK5
1AHL2	1CHK2	2CHK2	3BHL2	4BFL2	S5125	HAIL2	HDEK6
1AHL3	1CHK3	2CHK3	3BHL3	4BFL3	S5126	HAIL3	HDEK7
1AHL4	1CHK4	2CHK4	3BHL4	4BFL4	S5130	HAIL4	HDEK8
1AHL5	1CHK5	2CHK5	3BHL5	4BFL5	S5131	HAIL5	HDEL1
1AHL6	1CHK6	2CHK6	3BHL6	4BFL6	S5135	HAIL6	HDEL2
1AHLS	1CHKS	2CHKS	3BHLS	4BFLS	S5136	HAIL7	HDEL3
1AHLT	1CHKT	2CHKT	3BHLT	4BFLT	S5140	HAIL8	HDEL4
1AHLU	1CHKU	2CHKU	3BHLU	4BFLU	S5141	HAIM1	HDEL5
1AHLV	1CHKV	2CHKV	3BHLV	4BFLV	S5145	HAIM2	HDEL6
1AHLW	1CHKW	2CHKW	3BHLW	4BFLW	S5146	HAIM3	HDEL7
1AHLX	1CHKX	2CHKX	3BHLX	4BFLX	S5150	HAIM4	HDEL8
1AHM1	1CHL1	2CHL1	3BHM1	4BFM1	S5151	HAIM5	HDEM1
1AHM2	1CHL2	2CHL2	3BHM2	4BFM2	S5160	HAIM6	HDEM2
1AHM3	1CHL3	2CHL3	3BHM3	4BFM3	S5161	HAIM7	HDEM3
1AHM4	1CHL4	2CHL4	3BHM4	4BFM4	S5162	HAIM8	HDEM4
1AHM5	1CHL5	2CHL5	3BHM5	4BFM5	S5165	HBEJ1	HDEM5
1AHM6	1CHL6	2CHL6	3BHM6	4BFM6	S5170	HBEJ2	HDEM6
1AHMS	1CHLS	2CHLS	3BHMS	4BFMS	S5175	HBEJ3	HDEM7
1AHMT	1CHLT	2CHLT	3BHMT	4BFMT	S5180	HBEJ4	HDEM8
1AHMU	1CHLU	2CHLU	3BHMU	4BFMU	S5181	HBEJ5	HDFJ1
1AHMV	1CHLV	2CHLV	3BHMV	4BFMV	S5497	HBEJ6	HDFJ2
1AHMW	1CHLW	2CHLW	3BHMW	4BFMW	S5498	HBEJ7	HDFJ3
1AHMX	1CHLX	2CHLX	3BHMX	4BFMX	S5501	HBEJ8	HDFJ4
1AHN1	1CHM1	2CHM1	3BHN1	4BGK1	S5502	HBEK1	HDFJ5
1AHN2	1CHM2	2CHM2	3BHN2	4BGK2	S5517	HBEK2	HDFJ6
1AHN3	1CHM3	2CHM3	3BHN3	4BGK3	S5518	HBEK3	HDFJ7
1AHN4	1CHM4	2CHM4	3BHN4	4BGK4	S5520	HBEK4	HDFJ8
1AHN5	1CHM5	2CHM5	3BHN5	4BGK5	S5521	HBEK5	HDFK1
1AHN6	1CHM6	2CHM6	3BHN6	4BGK6	S5522	HBEK6	HDFK2
1AHNS	1CHMS	2CHMS	3BHNS	4BGKS	S5523	HBEK7	HDFK3
1AHNT	1CHMT	2CHMT	3BHNT	4BGKT	S9097	HBEK8	HDFK4
1AHNU	1CHMU	2CHMU	3BHNU	4BGKU	S9098	HBEL1	HDFK5
1AHNV	1CHMV	2CHMV	3BHNV	4BGKV	S9122	HBEL2	HDFK6
1AHNW	1CHMW	2CHMW	3BHNW	4BGKW	S9123	HBEL3	HDFK7
1AHNX	1CHMX	2CHMX	3BHNX	4BGKX	S9124	HBEL4	HDFK8
1AHP1	1CHN1	3AFK1	3BHP1	4BGL1	S9125	HBEL5	HDFL1
1AHP2	1CHN2	3AFK2	3BHP2	4BGL2	S9126	HBEL6	HDFL2
1AHP3	1CHN3	3AFK3	3BHP3	4BGL3	S9127	HBEL7	HDFL3
1AHP4	1CHN4	3AFK4	3BHP4	4BGL4	S9128	HBEL8	HDFL4
1AHP5	1CHN5	3AFK5	3BHP5	4BGL5	S9129	HBEM1	HDFL5
1AHP6	1CHN6	3AFK6	3BHP6	4BGL6	S9131	HBEM2	HDFL6
1AHPS	1CHNS	3AFKS	3BHPS	4BGLS	S9208	HBEM3	HDFL7
1AHPT	1CHNT	3AFKT	3BHPT	4BGLT	S9209	HBEM4	HDFL8
1AHPU	1CHNU	3AFKU	3BHPU	4BGLU	S9211	HBEM5	HDFM1
1AHPV	1CHNV	3AFKV	3BHPV	4BGLV	S9212	HBEM6	HDFM2
1AHPW	1CHNW	3AFKW	3BHPW	4BGLW	S9213	HBEM7	HDFM3
1AHPX	1CHNX	3AFKX	3BHPX	4BGLX	S9214	HBEM8	HDFM4
1BFK1	1CHP1	3AFL1	3CFK1	4BGM1	S9325	HBFJ1	HDFM5
1BFK2	1CHP2	3AFL2	3CFK2	4BGM2	S9326	HBFJ2	HDFM6
1BFK3	1CHP3	3AFL3	3CFK3	4BGM3	S9327	HBFJ3	HDFM7
1BFK4	1CHP4	3AFL4	3CFK4	4BGM4	S9328	HBFJ4	HDFM8
1BFK5	1CHP5	3AFL5	3CFK5	4BGM5	S9329	HBFJ5	HDGJ1
1BFK6	1CHP6	3AFL6	3CFK6	4BGM6	S9330	HBFJ6	HDGJ2

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Used to Identify excluded Home Health claims

PROC						New PROC (1)	Retired PROC (1)
1BFKS	1CHPS	3AFLS	3CFKS	4BGMS	S9331		HBFJ7	HDGJ3
1BFKT	1CHPT	3AFLT	3CFKT	4BGMT	S9336		HBFJ8	HDGJ4
1BFKU	1CHPU	3AFLU	3CFKU	4BGMU	S9338		HBFK1	HDGJ5
1BFKV	1CHPV	3AFLV	3CFKV	4BGMV	S9340		HBFK2	HDGJ6
1BFKW	1CHPW	3AFLW	3CFKW	4BGMW	S9341		HBFK3	HDGJ7
1BFKX	1CHPX	3AFLX	3CFKX	4BGMX	S9342		HBFK4	HDGJ8
1BFL1	2AFK1	3AFM1	3CFL1	4BHK1	S9343		HBFK5	HDGK1
1BFL2	2AFK2	3AFM2	3CFL2	4BHK2	S9345		HBFK6	HDGK2
1BFL3	2AFK3	3AFM3	3CFL3	4BHK3	S9346		HBFK7	HDGK3
1BFL4	2AFK4	3AFM4	3CFL4	4BHK4	S9347		HBFK8	HDGK4
1BFL5	2AFK5	3AFM5	3CFL5	4BHK5	S9348		HBFL1	HDGK5
1BFL6	2AFK6	3AFM6	3CFL6	4BHK6	S9349		HBFL2	HDGK6
1BFLS	2AFKS	3AFMS	3CFLS	4BHKS	S9351		HBFL3	HDGK7
1BFLT	2AFKT	3AFMT	3CFLT	4BHKT	S9353		HBFL4	HDGK8
1BFLU	2AFKU	3AFMU	3CFLU	4BHKU	S9355		HBFL5	HDGL1
1BFLV	2AFKV	3AFMV	3CFLV	4BHKV	S9357		HBFL6	HDGL2
1BFLW	2AFKW	3AFMW	3CFLW	4BHKW	S9359		HBFL7	HDGL3
1BFLX	2AFKX	3AFMX	3CFLX	4BHKX	S9361		HBFL8	HDGL4
1BFM1	2AFL1	3AFN1	3CFM1	4BHL1	S9363		HBFM1	HDGL5
1BFM2	2AFL2	3AFN2	3CFM2	4BHL2	S9364		HBFM2	HDGL6
1BFM3	2AFL3	3AFN3	3CFM3	4BHL3	S9365		HBFM3	HDGL7
1BFM4	2AFL4	3AFN4	3CFM4	4BHL4	S9366		HBFM4	HDGL8
1BFM5	2AFL5	3AFN5	3CFM5	4BHL5	S9367		HBFM5	HDGM1
1BFM6	2AFL6	3AFN6	3CFM6	4BHL6	S9368		HBFM6	HDGM2
1BFMS	2AFLS	3AFNS	3CFMS	4BHLS	S9370		HBFM7	HDGM3
1BFMT	2AFLT	3AFNT	3CFMT	4BHLT	S9372		HBFM8	HDGM4
1BFMU	2AFLU	3AFNU	3CFMU	4BHLU	S9373		HBGJ1	HDGM5
1BFMV	2AFLV	3AFNV	3CFMV	4BHLV	S9374		HBGJ2	HDGM6
1BFMW	2AFLW	3AFNW	3CFMW	4BHLW	S9375		HBGJ3	HDGM7
1BFMX	2AFLX	3AFNX	3CFMX	4BHLX	S9376		HBGJ4	HDGM8
1BFN1	2AFM1	3AFP1	3CFN1	4BHM1	S9377		HBGJ5	HDHJ1
1BFN2	2AFM2	3AFP2	3CFN2	4BHM2	S9379		HBGJ6	HDHJ2
1BFN3	2AFM3	3AFP3	3CFN3	4BHM3	S9381		HBGJ7	HDHJ3
1BFN4	2AFM4	3AFP4	3CFN4	4BHM4	S9490		HBGJ8	HDHJ4
1BFN5	2AFM5	3AFP5	3CFN5	4BHM5	S9494		HBGK1	HDHJ5
1BFN6	2AFM6	3AFP6	3CFN6	4BHM6	S9497		HBGK2	HDHJ6
1BFNS	2AFMS	3AFPS	3CFNS	4BHMS	S9500		HBGK3	HDHJ7
1BFNT	2AFMT	3AFPT	3CFNT	4BHMT	S9501		HBGK4	HDHJ8
1BFNU	2AFMU	3AFPU	3CFNU	4BHMU	S9502		HBGK5	HDHK1
1BFNV	2AFMV	3AFPV	3CFNV	4BHMV	S9503		HBGK6	HDHK2
1BFNW	2AFMW	3AFPW	3CFNW	4BHMW	S9504		HBGK7	HDHK3
1BFNX	2AFMX	3AFPX	3CFNX	4BHMX	S9537		HBGK8	HDHK4
1BFP1	2AGK1	3AGK1	3CFP1	4CFK1	S9538		HBGL1	HDHK5
1BFP2	2AGK2	3AGK2	3CFP2	4CFK2	S9542		HBGL2	HDHK6
1BFP3	2AGK3	3AGK3	3CFP3	4CFK3	S9558		HBGL3	HDHK7
1BFP4	2AGK4	3AGK4	3CFP4	4CFK4	S9559		HBGL4	HDHK8
1BFP5	2AGK5	3AGK5	3CFP5	4CFK5	S9560		HBGL5	HDHL1
1BFP6	2AGK6	3AGK6	3CFP6	4CFK6	S9562		HBGL6	HDHL2
1BFPS	2AGKS	3AGKS	3CFPS	4CFKS	S9590		HBGL7	HDHL3
1BFPT	2AGKT	3AGKT	3CFPT	4CFKT	S9810		HBGL8	HDHL4
1BFPU	2AGKU	3AGKU	3CFPU	4CFKU			HBGM1	HDHL5
1BFPV	2AGKV	3AGKV	3CFPV	4CFKV			HBGM2	HDHL6
1BFPW	2AGKW	3AGKW	3CFPW	4CFKW			HBGM3	HDHL7
1BFPX	2AGKX	3AGKX	3CFPX	4CFKX			HBGM4	HDHL8
1BGK1	2AGL1	3AGL1	3CGK1	4CFL1			HBGM5	HDHM1
1BGK2	2AGL2	3AGL2	3CGK2	4CFL2			HBGM6	HDHM2
1BGK3	2AGL3	3AGL3	3CGK3	4CFL3			HBGM7	HDHM3
1BGK4	2AGL4	3AGL4	3CGK4	4CFL4			HBGM8	HDHM4
1BGK5	2AGL5	3AGL5	3CGK5	4CFL5			HBHJ1	HDHM5
1BGK6	2AGL6	3AGL6	3CGK6	4CFL6			HBHJ2	HDHM6
1BGKS	2AGLS	3AGLS	3CGKS	4CFLS			HBHJ3	HDHM7
1BGKT	2AGLT	3AGLT	3CGKT	4CFLT			HBHJ4	HDHM8
1BGKU	2AGLU	3AGLU	3CGKU	4CFLU			HBHJ5	HDIJ1
1BGKV	2AGLV	3AGLV	3CGKV	4CFLV			HBHJ6	HDIJ2
1BGKW	2AGLW	3AGLW	3CGKW	4CFLW			HBHJ7	HDIJ3
1BGKX	2AGLX	3AGLX	3CGKX	4CFLX			HBHJ8	HDIJ4
1BGL1	2AGM1	3AGM1	3CGL1	4CFM1			HBHK1	HDIJ5

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Used to Identify excluded Home Health claims

PROC					New PROC (1)	Retired PROC (1)
1BGL2	2AGM2	3AGM2	3CGL2	4CFM2	HBHK2	HDIJ6
1BGL3	2AGM3	3AGM3	3CGL3	4CFM3	HBHK3	HDIJ7
1BGL4	2AGM4	3AGM4	3CGL4	4CFM4	HBHK4	HDIJ8
1BGL5	2AGM5	3AGM5	3CGL5	4CFM5	HBHK5	HDIK1
1BGL6	2AGM6	3AGM6	3CGL6	4CFM6	HBHK6	HDIK2
1BGLS	2AGMS	3AGMS	3CGLS	4CFMS	HBHK7	HDIK3
1BGLT	2AGMT	3AGMT	3CGLT	4CFMT	HBHK8	HDIK4
1BGLU	2AGMU	3AGMU	3CGLU	4CFMU	HBHL1	HDIK5
1BGLV	2AGMV	3AGMV	3CGLV	4CFMV	HBHL2	HDIK6
1BGLW	2AGMW	3AGMW	3CGLW	4CFMW	HBHL3	HDIK7
1BGLX	2AGMX	3AGMX	3CGLX	4CFMX	HBHL4	HDIK8
1BGM1	2AHK1	3AGN1	3CGM1	4CGK1	HBHL5	HDIL1
1BGM2	2AHK2	3AGN2	3CGM2	4CGK2	HBHL6	HDIL2
1BGM3	2AHK3	3AGN3	3CGM3	4CGK3	HBHL7	HDIL3
1BGM4	2AHK4	3AGN4	3CGM4	4CGK4	HBHL8	HDIL4
1BGM5	2AHK5	3AGN5	3CGM5	4CGK5	HBHM1	HDIL5
1BGM6	2AHK6	3AGN6	3CGM6	4CGK6	HBHM2	HDIL6
1BGMS	2AHKS	3AGNS	3CGMS	4CGKS	HBHM3	HDIL7
1BGMT	2AHKT	3AGNT	3CGMT	4CGKT	HBHM4	HDIL8
1BGMU	2AHKU	3AGNU	3CGMU	4CGKU	HBHM5	HDIM1
1BGMV	2AHKV	3AGNV	3CGMV	4CGKV	HBHM6	HDIM2
1BGMW	2AHKW	3AGNW	3CGMW	4CGKW	HBHM7	HDIM3
1BGMX	2AHKX	3AGNX	3CGMX	4CGKX	HBHM8	HDIM4
1BGN1	2AHL1	3AGP1	3CGN1	4CGL1	HBIJ1	HDIM5
1BGN2	2AHL2	3AGP2	3CGN2	4CGL2	HBIJ2	HDIM6
1BGN3	2AHL3	3AGP3	3CGN3	4CGL3	HBIJ3	HDIM7
1BGN4	2AHL4	3AGP4	3CGN4	4CGL4	HBIJ4	HDIM8
1BGN5	2AHL5	3AGP5	3CGN5	4CGL5	HBIJ5	Q5002
1BGN6	2AHL6	3AGP6	3CGN6	4CGL6	HBIJ6	S0345
1BGNS	2AHLS	3AGPS	3CGNS	4CGLS	HBIJ7	S0346
1BGNT	2AHLT	3AGPT	3CGNT	4CGLT	HBIJ8	S0347
1BGNU	2AHLU	3AGPU	3CGNU	4CGLU	HBIK1	
1BGNV	2AHLV	3AGPV	3CGNV	4CGLV	HBIK2	
1BGNW	2AHLW	3AGPW	3CGNW	4CGLW	HBIK3	
1BGNX	2AHLX	3AGPX	3CGNX	4CGLX	HBIK4	
1BGP1	2AHM1	3AHK1	3CGP1	4CGM1	HBIK5	
1BGP2	2AHM2	3AHK2	3CGP2	4CGM2	HBIK6	
1BGP3	2AHM3	3AHK3	3CGP3	4CGM3	HBIK7	
1BGP4	2AHM4	3AHK4	3CGP4	4CGM4	HBIK8	
1BGP5	2AHM5	3AHK5	3CGP5	4CGM5	HBIL1	
1BGP6	2AHM6	3AHK6	3CGP6	4CGM6	HBIL2	
1BGPS	2AHMS	3AHKS	3CGPS	4CGMS	HBIL3	
1BGPT	2AHMT	3AHKT	3CGPT	4CGMT	HBIL4	
1BGPU	2AHMU	3AHKU	3CGPU	4CGMU	HBIL5	
1BGPV	2AHMV	3AHKV	3CGPV	4CGMV	HBIL6	
1BGPW	2AHMW	3AHKW	3CGPW	4CGMW	HBIL7	
1BGPX	2AHMX	3AHKX	3CGPX	4CGMX	HBIL8	
1BHK1	2BFK1	3AHL1	3CHK1	4CHK1	HBIM1	
1BHK2	2BFK2	3AHL2	3CHK2	4CHK2	HBIM2	
1BHK3	2BFK3	3AHL3	3CHK3	4CHK3	HBIM3	
1BHK4	2BFK4	3AHL4	3CHK4	4CHK4	HBIM4	
1BHK5	2BFK5	3AHL5	3CHK5	4CHK5	HBIM5	
1BHK6	2BFK6	3AHL6	3CHK6	4CHK6	HBIM6	
1BHKS	2BFKS	3AHLS	3CHKS	4CHKS	HBIM7	
1BHKT	2BFKT	3AHLT	3CHKT	4CHKT	HBIM8	
1BHKU	2BFKU	3AHLU	3CHKU	4CHKU	HCEJ1	
1BHKV	2BFKV	3AHLV	3CHKV	4CHKV	HCEJ2	
1BHKW	2BFKW	3AHLW	3CHKW	4CHKW	HCEJ3	
1BHKX	2BFKX	3AHLX	3CHKX	4CHKX	HCEJ4	
1BHL1	2BFL1	3AHM1	3CHL1	4CHL1	HCEJ5	
1BHL2	2BFL2	3AHM2	3CHL2	4CHL2	HCEJ6	
1BHL3	2BFL3	3AHM3	3CHL3	4CHL3	HCEJ7	
1BHL4	2BFL4	3AHM4	3CHL4	4CHL4	HCEJ8	
1BHL5	2BFL5	3AHM5	3CHL5	4CHL5	HCEK1	
1BHL6	2BFL6	3AHM6	3CHL6	4CHL6	HCEK2	
1BHLS	2BFLS	3AHMS	3CHLS	4CHLS	HCEK3	
1BHLT	2BFLT	3AHMT	3CHLT	4CHLT	HCEK4	

Appendix C - 2
HCPCS Associated with Milliman Grouper Line
Used to Identify excluded Home Health claims

PROC					New PROC (1)	Retired PROC (1)
1BHLU	2BFLU	3AHMU	3CHLU	4CHLU		HCEK5
1BHLV	2BFLV	3AHMV	3CHLV	4CHLV		HCEK6
1BHLW	2BFLW	3AHMW	3CHLW	4CHLW		HCEK7
1BHLX	2BFLX	3AHMX	3CHLX	4CHLX		HCEK8
1BHM1	2BFM1	3AHN1	3CHM1	4CHM1		HCEL1
1BHM2	2BFM2	3AHN2	3CHM2	4CHM2		HCEL2
1BHM3	2BFM3	3AHN3	3CHM3	4CHM3		HCEL3
1BHM4	2BFM4	3AHN4	3CHM4	4CHM4		HCEL4
1BHM5	2BFM5	3AHN5	3CHM5	4CHM5		HCEL5
1BHM6	2BFM6	3AHN6	3CHM6	4CHM6		HCEL6
1BHMS	2BFMS	3AHNS	3CHMS	4CHMS		HCEL7
1BHMT	2BFMT	3AHNT	3CHMT	4CHMT		HCEL8
1BHMU	2BFMU	3AHNU	3CHMU	4CHMU		HCEM1

(1) Codes added or removed from Milliman grouper logic since latest list of procedure codes provided.

Appendix D
Diagnosis Codes Associated with SPMI flag

SPMI		Serious Emotional Disturbance (SED)				
29500	29655	29500	29613	30110	F321	F40233
29501	29656	29501	29614	30111	F322	F40240
29502	29660	29502	29615	30112	F323	F40241
29503	29661	29503	29616	30113	F324	F40242
29504	29662	29504	29620	30120	F325	F40243
29505	29663	29505	29621	30121	F3340	F40248
29510	29664	29510	29622	30122	F339	F40290
29511	29665	29511	29623	3013	F330	F40291
29512	29666	29512	29624	3014	F331	F40298
29513	2967	29513	29625	30150	F332	F408
29514	29689	29514	29626	30151	F333	F42
29515	29633	29515	29630	30159	F3341	F341
29520	29634	29520	29631	3016	F3342	F600
29521	2971	29521	29632	30189	F310	F340
29522	2989	29522	29633	3019	F3110	F6089
29523	30183	29523	29634	3071	F3189	F601
29524	F2089	29524	29635	30720	F3111	F21
29525	F201	29525	29636	30721	F3112	F603
29530	F202	29530	29640	30722	F3113	F605
29531	F200	29531	29641	3073	F312	F604
29532	F205	29532	29642	30750	F3173	F6810
29533	F203	29533	29643	30751	F3174	F6812
29534	F209	29534	29644	30752	F3130	F6813
29535	F23	29535	29645	30753	F3131	F607
29550	F250	29540	29646	30754	F3132	F609
29551	F251	29541	29650	30759	F314	F69
29552	F258	29542	29651	3076	F315	F5000
29553	F259	29543	29652	3077	F3175	F5001
29554	F3010	29544	29653	30921	F3176	F5002
29555	F309	29545	29654	30981	F3160	F958
29560	F3011	29550	29655	311	F3161	F959
29561	F3012	29551	29656	3130	F3162	F950
29562	F3013	29552	29660	3131	F3163	F951
29563	F302	29553	29661	31321	F3164	F984
29564	F303	29554	29662	31322	F3177	F509
29565	F304	29555	29663	31323	F3178	F502
29590	F310	29560	29664	31381	F3170	F983
29591	F3110	29561	29665	31382	F3171	F9821
29592	F3189	29562	29666	31383	F3172	F508
29593	F3111	29563	2967	31389	F319	F9829
29594	F3112	29564	29680	3139	F308	F980
29570	F3113	29565	29681	31400	F328	F981
29571	F312	29580	29682	31401	F3181	F930
29572	F3173	29581	29689	3141	F39	F4310
29573	F3174	29582	29690	3142	F338	F4311
29574	F3130	29583	29699	3148	F348	F4312
29600	F3131	29584	2970	3149	F349	F938
29601	F3132	29585	2971	F2089	F22	F940
29602	F314	29590	2978	F201	F28	F913
29603	F315	29591	2979	F202	F4489	F941
29604	F3175	29592	2980	F200	F29	F942
29605	F3176	29593	2981	F2081	F419	F949

Attachment 6 - 20210616 MMCP and IMPlus Rate Certification

Calendar Year 2021 Capitation Rate Development:

Medicaid Rates for Dual Eligible Clients Enrolled in Medicare-Medicaid Coordinated Plan (MMCP) and Idaho Medicaid Plus (IMPlus) Programs
State of Idaho

Prepared for:
Idaho Department of Health and Welfare (IDH&W)

Prepared by:
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June 16, 2021

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Appendices

M1. EXECUTIVE SUMMARY

INTRODUCTION

The Idaho Department of Health and Welfare (IDH&W) retained Milliman, Inc. (Milliman) to develop actuarially sound Medicare-Medicaid Coordinated plan (MMCP) and Idaho Medicaid Plus (IMPlus) rates. This report outlines the data, assumptions, and ratesetting methodology used in the calendar year (CY) 2021 capitation rate development for the enrolled dual Medicare and Medicaid members.

This report includes the actuarial certifications for both programs. Due to the similarity of the data, assumptions, and ratesetting methodology for the MMCP and IMPlus programs, the narrative addresses both programs concurrently to facilitate review and also to highlight areas where there are material distinctions. Since the contracts are developed separately for each of these programs, we have created two separate certifications within the full report.

On an annual basis, Milliman completes an analysis of the actuarial soundness of rates for the dual eligible enrollees covered under MMCP and IMPlus. The covered services considered for rate development fall within two major service categories: Long Term Services and Supports (LTSS) and medical, including behavioral health and pharmacy. Blue Cross of Idaho (BCI) and Molina are the only two participating MMCP and IMPlus managed care organizations (MCOs).

Rates are developed separately for each vendor and program. However, the overall program structures are similar, with the primary difference being mandatory versus voluntary enrollment. Eligible members can be enrolled in one program or the other, but not both. Due to the partial geographic footprint of these programs in the state of Idaho, not all dual Medicare and Medicaid eligible members participate in these programs. There are services for eligible members that are also provided under fee-for-service (FFS) or other managed care arrangements. Note that enrollment in the MMCP and the IMPlus programs will result in disenrollment from the State's managed care behavioral health program.

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined by CMS in the 2020-2021 Medicaid Managed Care Rate Development Guide (CMS Guide), published July 2, 2020:

> The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
>
> The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity; and
>
> The documentation is sufficient to demonstrate that the rate development process meets requirements of 42 CFR part 438 and generally accepted actuarial principles and practices.

CMS Guide Index [Section I.1.B]

We indexed each section of this report to the corresponding section of the "2020-2021 Medicaid Managed Care Rate Development Guide". For example, the contents within the brackets above refer to Section I, subsection 1 "General Information", bullet B "Appropriate Documentation". This notation appears in the table of contents as well as the body of this rate certification.

CAPITATION RATES

The monthly capitation rates for the contract period of January 1, 2021 – December 31, 2021 are $1,622.94 for BCI and $1,142.28 for Molina for members enrolled in the MMCP program and $1,825.10 for BCI and $1,650.74 for Molina for members enrolled in the IMPlus program.

Both the current CY 2021 rates and the prior CY 2020 rates for BCI and Molina are summarized in the Table 1a (MMCP) and Table 1b (IMPlus), below.

Table 1a
Idaho Department of Health and Welfare
Medicare Medicaid Coordinated Plan (MMCP)
Summary of Rate Changes

Carrier	CY20 Certified Rate	CY21 Certified Rate	Rate Change	% Change
BCI	$1,307.72	$1,622.94	$315.23	24.1%
Molina	$1,304.62	$1,142.28	($162.34)	-12.4%

Table 1b Idaho Department of Health and Welfare Idaho Medicaid Plus (IMPlus) Summary of Rate Changes				
Carrier	**CY20 Certified Rate**	**CY21 Certified Rate**	**Rate Change**	**% Change**
BCI	$1,400.03	$1,825.10	$425.07	30.4%
Molina	$1,399.65	$1,650.74	$251.10	17.9%

As these rates represent the composite amount across several underlying level of care groupings, they are highly sensitive to changes in the underlying enrollment mix assumptions for the rating period for each MCO and program. In general, with the exception of the MMCP capitation rate for Molina, the capitation rates represent increases from the CY 2020 certified rates. If the CY 2020 certified rates were adjusted to reflect the same member mix assumption used in the development of the CY 2021 certified rates, the rate increases would range from 11.8% to 15.4%, driven by increased costs observed in the base period data.

As discussed in further detail below, the final rates will be adjusted in arrears in order to reflect the actual member mix enrolled for the year across the various level of care groupings and settle to a Medical Loss Ratio (MLR) that lies within the +/- 3% corridor of the 88% target.

APPENDICES

Appendix A includes additional detail around the development of the CY2021 capitation rates.

M2. MEDICAID MANAGED CARE RATES [SECTION I]

GENERAL INFORMATION [SECTION I.1]

Rate Development Standards [Section I.1.A]

Rating Period [Section I.1.A.i]:

This rate certifications are for a 12-month rating period effective January 2021 to December 2021.

Items included in an acceptable rate certification [Section I.1.A.ii]:

a. *A letter from the certifying actuary:*

See Section M6 and M7 for the rate certifications at the end of this report.

b. *The final and certified capitation rates for all rate cells:*

The final and certified rates eligible for federal financial participation can be found in Tables 1a and 1b above.

Appendix A steps through the adjustments to reach a final capitation payment for each MCO and program.

- State Fiscal Year (SFY) 2019 FFS data provided by IDH&W was summarized for all counties statewide by level of care and limited to covered services and program eligible members.
- The following adjustments are applied to project these claim costs to CY 2021:
  - Adjustment for annual utilization and unit cost trends to CY 2021.
  - Adjustment to reflect relativities of covered counties compared to statewide experience.
  - Adjustment to reflect the management impact of the MCOs compared to the FFS experience ("One Time Adjustment - Management").
- A quality improvement (QI) load is applied.
- A non-benefit expense load (net of QI) is applied.

Additional information regarding the development of the CY 2021 MMCP and IMPlus rates is detailed in this report.

c. *Descriptions of the program:*

Table 2 shows the key components of each program

Table 2
Idaho Department of Health and Welfare
MMCP and IMPlus
Comparison of Key Program Components

	MMCP	IMPlus
Enrollment	Voluntary	Mandatory if not enrolled in MMCP (members enrolled passively for counties with only a single vendor)
Population	Dual Adults, including DD waiver	Dual Adults, excluding DD waiver
Health Plan Vendors	BCI (original) Molina (as of January 2018)	BCI & Molina (both effective November 2018)
Medicare coverage requirement	Beneficiary also enrolled in Medicaid health plan's Medicare Advantage plan	N/A
Covered Services	Medical + LTSS, described in data section below	Medical + LTSS, described in data section below
Counties Covered	30 – BCI 21 – Molina	30 – BCI 21 – Molina
Rate Cell Blending	Retrospectively adjusted for actual enrollment mix	Retrospectively adjusted for actual enrollment mix
MLR settlement	88% target +/- 3%	88% target +/- 3%

The details surrounding the MMCP and IMPlus programs are expanded upon below.

(i) A summary of the specific state Medicaid managed care programs covered by the rate certification, including, but not limited to:

(A) The types and numbers of managed care plans included in the rate development:

For these programs, the state is currently served by two managed care organizations (MCOs), BCI and Molina.

Some counties are not covered by these programs and are still covered primarily by Medicaid FFS, with some behavioral health services covered through the managed care program capitated through Optum.

(B) A general description or list of the benefits that are required to be provided by the managed care plan or plans:

The covered services considered for rate development fall within two major service categories: LTSS and medical. The set of covered services, which are parts of the state plan, are the same for all members enrolled in the MMCP and IMPlus programs.

LTSS services include home and community-based services for individuals with physical disabilities and individuals over age 65, in addition to institutional services in long-term care facilities. Medical services include physical health, behavioral health, and prescription drugs. All covered services are consistent with those provided through the Medicaid FFS program and the State Plan.

(C) The areas of the state covered by the managed care rates and approximate length of time the managed care program has been in operation.

Since inception, MMCP has been a voluntary program that covers dual Medicare and Medicaid eligible enrollees. Prior to July 2014, the MMCP program existed in a different form, requiring enrollment in a Medicare Advantage plan, and covering fewer services (mostly cost sharing for Medicare covered services and some limited state plan medical services, excluding LTSS).

In July 2014, the current structure of the MMCP program rolled out and included coverage for LTSS. Since the initial rollout of the program, there have only been small changes to the program's covered services. BCI was formerly the only vendor.

In January 2018, Molina joined the MMCP program as the second vendor.

In November 2018, the state also began offering a mandatory program, Idaho Medicaid Plus (IMPlus), which is similar in design and structure to the MMCP program. Eligible members in covered counties who do not voluntarily enroll in the MMCP program are automatically enrolled into the IMPlus program.

Effective April 1, 2020, BCI has offered MMCP and IMPlus program coverage in 30 counties statewide, while Molina has offered coverage in 21 counties statewide. In the 9 counties where BCI is the only vendor, members are permitted to opt-out after passive enrollment into the IMPlus program.

Please see Appendix B for the full list of covered counties.

(ii) Rating period:

The rating period covered by this rate certification is CY 2021.

(iii) Covered populations:

Only the dual adult population is covered under these programs. The DD waiver population (identified by secondary aid code) will not be enrolled in IMPlus (while they can choose to voluntarily enroll in the MMCP program).

Note that since these rates only cover dual Medicare and Medicaid members, the Medicaid expansion that occurred in Idaho in January 2020 does not contribute additional members to these programs.

(iv) Eligibility and enrollment criteria:

Enrollment in the managed care plan is voluntary for the covered population in covered counties for the MMCP program. Eligible members in covered counties who do not voluntarily enroll in the MMCP program are automatically enrolled into the IMPlus program.

(v) Special contract provisions:

As is discussed in more detail below, the final rates will be adjusted in arrears in order to reflect the actual member mix enrolled for the year across the various level of care groupings and settle to a Medical Loss Ratio (MLR) that lies within the +/- 3% corridor of the 88% target.

(vi) Retroactive Adjustments:

Not applicable.

Differences between covered populations [Section I.1.A.iii]:

Any differences among capitation rates according to covered populations are based on valid rate development standards (such as differences in historical experience) and are not based on the rate of federal financial participation associated with the covered populations.

Cross-subsidization [Section I.1.A.iv]:

Capitation rates were developed such that payments from any level of care do not cross-subsidize payments from any other level of care. Note that there is only one certified rate for each combination of program and vendor due to the structure of the contract. Projected rates by individual level of care groupings are blended based on the expected membership mix over the contract period to calculate the composite rate. The composite payment rates for the programs will be adjusted annually on a retrospective basis to reflect the actual mix of members enrolled across the individual level of care groupings.

Consistency of effective dates [Section I.1.A.v]:

The effective dates of changes to the Medicaid managed care program (including eligibility, benefits, and payment rate requirements) are consistent with the assumptions used to develop the capitation rates. These changes have been summarized in Section M1. Executive Summary, with detail included within the assumption documentation sections.

Considerations for MLR standards [Section I.1.A.vi]:

Capitation rates have been developed in such a way that each vendor and each program would reasonably achieve a MLR, as calculated under 42 CFR §438.8, of at least 85 percent for the rate year. In addition, as described in further detail below, the programs include a retrospective MLR settlement arrangement with a minimum MLR equal to 85 percent.

Considerations for CMS [Section I.1.A.vii]: *As part of CMS's determination of whether or not the rate certification submission and supporting documentation adequately demonstrate that the rates were developed using generally accepted actuarial practices and principles, CMS will consider whether the submission demonstrates the following:*

a. *all adjustments are reasonable, appropriate, and attainable in the actuary's judgment.*

   All adjustments applied during the capitation rate development have been documented herein and are certified as part of the overall rates as reasonable, appropriate, and attainable by the certifying actuary.

b. *adjustments to the rates that are performed outside of the rate setting process described in the rate certification are not considered actuarially sound under 42 CFR §438.4.*

   We have not made additional adjustments outside the rate setting process documented herein.

c. *consistent with 42 CFR §438.7(c), the final contracted rates in each cell must match the capitation rates in the rate certification. This is required in total and for each and every rate cell.*

   It is our understanding that the final contractual rates paid to the managed care entities for each member enrolled in the respective program(s) (prior to the retrospective adjustment to reflect the actual realized member mix) are consistent with the capitation rates included in Table 1.

Certification period [Section I.1.A.viii]:

Rates are effective and certified for January 2021 through December 2021.

Procedures for rate certifications for rate and contract amendments [Section I.1.A.ix]:

Not applicable.

Appropriate Documentation [Section I.1.B]

Documentation detail required [Section I.1.B.i]: *States and their actuaries must document all the elements described within their rate certifications to provide adequate detail that CMS is able to determine whether or not the regulatory standards are met. In evaluating the rate certification, CMS will look to the reasonableness of the information contained in the rate certification for the purposes of rate development and may require additional information or documentation as necessary to review and approve the rates. States and their actuaries must ensure that the following elements are properly documented:*

a. *Data used, including citations to studies, research papers, other states' analyses, or similar secondary data sources.*

The base claims data used to develop the capitation rates is a combination of historical FFS data plus behavioral health encounter data from state fiscal year (SFY) 2019 (July 1, 2018 – June 30, 2019), including run-out claims through September 2019.

Specifically, we relied on the following base data sources:

- Historical FFS data
  - Detailed claims data
    - Used for all LTSS categories of service
    - Used for most Medical categories of service (other than behavioral health)
  - Detailed eligibility files for both Medicaid-only and dual-eligible enrollees, including a flag indicating the enrollees' Medicaid-only or dual-eligibility status, as well as secondary aid code.
- Encounter data provided by the state's behavioral health managed care organization (Optum)
  - We have included these managed care costs in our rate calculations since services Optum provides for the FFS members are provided by BCI or Molina for the MMCP and IMPlus program participants. Within the base period SFY2019 data, behavioral health costs are the only services included that were provided under managed care.

The State of Idaho provided this data for all Medicaid enrollees, but the data considered for MMCP and IMPlus rate projections is restricted to those dual eligible enrollees in the FFS program that are eligible for the programs. This subset of FFS data was determined to be sufficiently credible for use in rate projections.

b. *Assumptions made:*

Details supporting all assumptions are provided throughout this document. The following adjustments have been applied during rate development:

- Restrict base period claims data to only eligible members in the FFS program and services covered under the duals' programs
- Adjust for claims incurred but not paid (IBNP)
- Management adjustments to account for differences observed between FFS data and actual managed care program experience
- Unit cost and utilization trends from the base period (SFY 2019) to the projection period (CY 2021)
- Area adjustment to reflect covered counties
- QI and Non-Benefit expenses

c. *Methods for analyzing data and developing assumptions and adjustments:*

Methodology applied in analyzing data and developing assumptions and adjustments are described throughout this document where assumptions are identified.

Assumptions and adjustments [Section I.1.B.ii]: *CMS understands that there are instances where actuaries develop ranges around various assumptions and adjustments. We believe this is a valid and appropriate approach to aid in the development and selection of the final assumptions that underlie the certified capitation rates, but note that actuaries must certify specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c), and it is not permissible to certify rate ranges. Therefore, the actuary must be responsible for all assumptions and adjustments underlying the certified capitation rates, and the certification must disclose and support the specific assumptions that underlie the certified rates for each rate cell, including the magnitude and narrative support for each specific assumption or adjustment that underlies the certified rates for each rate cell. To the extent assumptions or adjustments underlying the capitation rates varies between managed care plans, the certification must also describe the basis for this variation.*

Rates are based on point estimates and ranges were not used. Specific rates have been developed separately for each combination of program and vendor. The language throughout this memorandum details situations in which the assumptions or adjustments underlying the capitation rates vary between MCOs in compliance with [Section I.1.B.ii].

Rate certification index [Section I.1.B.iii]

The table of contents of this document serves as the rate certification index.

Differences in FMAP [Section I.1.B.iv]

There are no rate development assumptions or methodologies that differ based on the rate of FMAP.

Managed care program additional documentation requests [Section I.1.B.v]

a. *Comparison to previous certified rates*

The change in rates compared to the CY 2020 rates is shown in Table 1a and Table 1b.

b. *Description of any material changes to the rates or rate development process not addressed elsewhere*

Not applicable.

List of known amendments [Section I.1.B.vi]

Not applicable.

DATA [SECTION I.2]

Rate Development Standards [Section 1.2.A]

Base data standards [Section I.2.A.i]:

a. *Validated data and audited financial reports*

The IDH&W provided validated data for use in rate development, from which we were able to identify eligible duals' program members, which was used to develop the starting point for this rate build. We have not audited or verified this data and other information, but we did compare data provided to historical FFS data and associated control totals provided by the IDH&W for reasonableness. We also compared the Optum encounter data to the financial summaries provided.

b. *Appropriate base data period*

We constructed rates using SFY 2019 claims data provided by the IDH&W, which was the most recent complete year of data available at the time of the analysis.

c. *Appropriate base data population*

We restricted the data from IDH&W to only include the dual beneficiaries covered under this certification and enrolled in the FFS program. IMPlus did not yet initiate until mid-way through SFY 2019, with expansion to all currently covered counties not occurring until April 2020. Therefore, many duals were still covered under the traditional FFS Medicaid program.

Dual beneficiaries are identified based on a full dual indicator flag on the data as well as the member's Medicaid aid category code. Dual beneficiaries that would be eligible for premium assistance through Medicaid, but are not eligible for state plan services under Medicaid (Qualified Medicare Beneficiary, or QMB, and Specified Low Income Medicare Beneficiary or SLMB), are not included in the data underlying the MMCP and IMPlus rate projections. Members under the age of 21 are excluded as they are not eligible for the programs. For IMPlus, eligible members with a secondary aid code identifying them as DD are also removed from the projection.

While dual beneficiaries already participating in the MMCP or IMPlus programs in SFY 2019 are part of the covered population, we have excluded this population for purposes of the rate projections. See the additional discussion in Section I.2.B.ii.c.ii below.

d. *Alternative data sources*

Not applicable.

Appropriate Documentation [Section I.2.B]

Description of data requested [Section I.2.B.i]: *In accordance with 42 CFR §438.7(b)(1), the rate certification must include:*

a. *A description of base data requested and used for the rate setting process, including:*

(i) A summary of the base data that was requested by the actuary.

FFS detailed claims and eligibility files were requested from IDH&W, along with behavioral health detailed claims, eligibility, capitation files, and financial reports.

(ii) A summary of the base data that was provided by the state.

All requested data was provided.

(iii) An explanation of why any base data requested was not provided by the state.

Not applicable.

Description of data used to develop rates [Section I.2.B.ii]: *The rate certification, as supported by the assurances from the state, must thoroughly describe the data used to develop the capitation rates, including:*

a. *Description of the data.*

We utilized FFS data and managed care encounter data.

We used the SFY 2019 FFS and behavioral health encounter data for the base period benefit costs.

We received all data related to the base population from the DH&W. Some assumptions were developed using information based on prior ratesetting assumptions, program experience, our experiences with other states, and Milliman research.

There are no sub-capitated costs in the base experience period.

While we used actual MCO program experience to adjust the base period FFS costs by level of care to the cost levels observed in the actual MMCP and IMPlus program experience, we relied primarily on FFS program data as the basis for rate projections due to the low credibility of actual dual's program data. See further discussion on the use of actual MCO encounter data to inform management adjustments in section I.3.B.ii below.

b. *Data availability and quality:*

(i) the steps taken by the actuary or by others (e.g., State Medicaid Agency; health plans; external quality review organizations; financial auditors; etc.) to validate the data, including:

(A) completeness of the data.

(B) accuracy of the data.

(C) consistency of the data across data sources.

We processed this baseline data through Milliman's Health Cost Guidelines (HCG) Grouper and summarized by detailed service categories. This processing includes checking for duplicates and checking for membership matches against the eligibility file. The HCG Grouper consolidates the claim details and assigns detailed service categories. The resulting summaries allow us to evaluate the data for reasonableness and compare to prior SFY data and other data sources. For example, we compared the Optum encounter data to the financial summaries they also provided.

Using the processed data, we were able to calculate historical utilization and unit cost levels, as well as the resulting PMPM costs. These summaries allow us to evaluate the data for reasonableness and compare to prior SFY data and other data sources. We were able to determine that the data is complete, accurate, and consistent, and we have no material concerns about the data quality. We have not performed a formal audit of the data. Data was not provided with the ultimate run-out of claims, so an adjustment was made to complete the base data for claims incurred but not paid (divide by 0.983).

(ii) a summary of the actuary's assessment of the data.

As the certifying actuary, I have assessed the quality of available data to be sufficient for the purpose of developing projected capitation rates effective during the contract period for the covered population.

All data were reviewed at several levels by consultants, actuaries, and data analysts who have experience with Medicaid data. We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent.

(iii) any other concerns that the actuary has over the availability or quality of the data.

Not applicable.

c. *Data appropriateness: a description of how the actuary determined what data was appropriate to use for the rating period, including:*

(i) *if fee-for-service claims or managed care encounter data are not used (or are not available), this description should include an explanation of why the data used in rate development is appropriate for setting capitation rates for the populations and services to be covered.*

Not applicable. Recent FFS claims and managed care encounter data for the covered populations was used.

(ii) *if managed care encounter data was not used in the rate development, this description should include an explanation of why encounter data was not used as well as any review of the encounter data and the concerns identified which led to not including the encounter data.*

Milliman also requested, and the State provided, MCO encounter data and associated financial reports related to the experience for members enrolled in the MMCP and IMPlus programs. This claims data was excluded from the base period data used in rate projections. Eligible enrollees in these programs were excluded in the base period for both Medical and LTSS categories of service during their time of enrollment in the programs. We did, however, review the MCO encounter data provided by IDH&W and used it to inform a number of assumptions. Our analysis of this data did not uncover any significant concerns or material defects. The population during the base period enrolled in the MMCP and IMPlus programs is a small subset of the overall eligible population (approximately 17% enrolled in the MMCP program in SFY 2019 and 5% enrolled in the IMPlus program in SFY 2019). Therefore, we chose to use the credible base period claims data for members covered under the FFS program and use the vendor specific encounter data to inform other assumptions underlying the rate projections.

d. *Reliance on a data book:*

Not applicable.

Description of data adjustments [Section I.2.B.iii]:

a. *Credibility:*

Not applicable.

b. *Completion factors:*

Data was provided with paid dates through September 2019, without the ultimate run-out of claims, so an adjustment was made to complete the base data for claims incurred but not paid (IBNP). Completion factors were developed by service category, using the following groupings:

- Mental Health and Physical Health
- Long Term Care and Developmental Disability
- Prescription Drug

These factors were applied based on incurred month. As a result, the overall IBNP factor varied by each level of care grouping. For SFY 2019, the aggregate expected completion factor was approximately 0.983. We divided the paid amounts by this factor to gross up the base period claims to expected ultimate incurred claims.

c. *Data errors:*

Not applicable.

d. *Program changes:*

There were no material program changes between SFY 2019 and CY 2021. However, the FFS data includes a number of services that were not covered under the MMCP and IMPlus programs, including in SFY 2019.

A subset of the FFS claims are removed from consideration in our rate projections at the direction of the State. Our understanding is that these services remain covered for enrollees under another mutually exclusive program or waiver.

We adjusted the base period claims data by removing services that the MMCP and IMPlus programs do not cover.

The services explicitly removed are the following:

- Dental Services
- Hearing Exams
    - Based on Milliman's HCG Grouper assigned MR_Line = 'P45'

    - See Appendix C-1 for HCPCS codes associated with this MR_Line
- Home Health
    - Based on Milliman's HCG Grouper assigned MR_Line = 'P82'
    - See Appendix C-2 for HCPC codes associated with this MR_Line
- Select DD lines, identified based on srcSpecialty code (for only members with a secondary aid code of '14')
    - C00304597 Chore Services
    - C00304639 Behavior Consultation/Crisis Management
    - C00304641 Contractor-Home Modifications
    - C00304643 Certified Family Home (CFH)
    - C00304647 Residential Habilitation Agency
    - C00304649 DD Case Management
    - C00304693 Developmental Disability Agency
    - C00304709 Children's Service Coordination
    - C00305195 Respite Care
    - C00305225 Supported Employment Services
    - C00305227 Supports Brokerage-FEA
    - C00304827 Agency Transportation
- Select transportation lines, identified based on srcSpecialty code (for all members except those with secondary aid code '15')
    - C00307106 Individual Transportation Provider
    - C00307104 Commercial Transportation
- School based services: srcSpecialty code 'C00304811'
- Service Coordination Crisis Assistance
    - HCPCS = 'H2011' and no modifier
    - We understand this is provided by the health plan as part of their non-benefit expense add-on
- Intermediate Care Facility
    - srcSpecialty = 'C00306255'
- Targeted services coordination
    - HCPCS = 'G9007' and no modifier
    - HCPCS = 'H2011' and Modifier = 'HM'
    - HCPCS = 'G9002' and no Modifier and secondary aid code of '14'
    - HCPCS = 'G9002' and Modifier = 'HM' and secondary aid code of '14'
- Behavioral Crisis Consultation
    - HCPCS = 'H2019'
- We include srcSpecialty 'C00304561' Audiologist, even if it would have been excluded by above logic

We excluded claims identified via the above criteria from the base period rather than applying a programmatic adjustment from the base period to the projection period, as the FFS program continues to cover these expenditures and most of these services have been excluded since the introduction of the programs.

There were no changes to the covered services in CY 2021 as compared to the CY 2020 rate certification.

e. *Exclusions:*

Not applicable.

PROJECTED BENEFIT COSTS AND TRENDS [SECTION I.3]

Rate Development Standards [Section I.3.A]

Services in final rates [Section I.3.A.i]:

Final capitation rates are based only upon the services allowed in 42 CFR §438.3(c)(1)(ii) and 438.3(e).

Variations in assumptions [Section I.3.A.ii]:

Variations in the assumptions used to develop the projected benefit costs for covered populations are based on valid rate development standards and not based on the rate of federal financial participation associated with the covered populations.

Development of benefit cost trends [Section I.3.A.iii]:

See section I.3.B.iii.

In-lieu-of services [Section I.3.A.iv]:

Not applicable.

Costs associated with IMDs [Section I.3.A.v]:

The vendors are expected to provide IMD coverage for SPMI and SUD members between 18-64 years old, to align with the filed 1115 Waiver, which came into effect in April of 2020. While this Waiver effectuated after the SFY2019 base period, the impact of this expanded coverage on the dual program population is expected to be immaterial. The base period experience is consistent with what is allowable in the approved waiver and no explicit adjustments were made to the underlying trend assumptions to reflect this change. We expect utilization of IMDs by the covered population in the rating period to be immaterial.

Appropriate Documentation [Section I.3.B]

Projected benefit costs [Section I.3.B.i]:

Appendix A shows the development of the projected benefit costs.

Development of projected benefit costs [Section I.3.B.ii]:

a. *Description of the data, assumptions and methodologies used to develop the projected benefit costs.*

We relied on data supplied by the IDH&W, conversations with the IDH&W, internal Milliman research and publicly available data sources to develop assumptions to adjust the base period data and produce projected benefit cost estimates.

We evaluate the costs separately for LTSS and medical expenditures. Within each service category, we expand the population types to a slightly different level of granularity for the associated level of care groupings. Lastly, due to operational constraints, the final rate is calculated as a composite of all level of care level groupings, based on an assumed, projected membership mix. Over the course of each contract period, the actual membership mix is re-evaluated retrospectively for comparison to the original assumptions. The revised composite rate for actual membership mix is then used within the MLR settlement calculation. Material changes in the membership mix will result in an update to the PMPM capitation rate. The logic of member categorization used for rate development is consistent with the logic used for the program's retrospective MLR settlement. Note however that in determining the membership mix as a part of the retrospective MLR settlement calculation, the member level of care is held static at the assigned level of care as of three months prior to the start of each contract period to incentivize movement to lower cost level of care groupings throughout the contract year. These groupings and service category splits are described in further detail below.

For the LTSS cost projections, we categorize members as: Institutional Level of Care (ILOC) – Institutional, ILOC – HCBS, Community Well 21-44, Community Well 45 – 64, or Community Well 65+. We categorize members as ILOC - Institutional in a particular month if they have had 21 or more days of nursing facility services within that month. Members who are not identified as institutional in a given month are categorized as ILOC - HCBS if they have received long-term care category of service claims outside of a nursing facility. The specific logic for determining member status is included in Appendix E. We consider all other members to be Community Well. The Community Well level of care is further subdivided based on the member's age in the master eligibility file (21-44, 45-64, and 65+).

When developing cost projections for medical services, we categorize members into a different set of level of care groupings: ILOC, Community Well – DD, Community Well – SPMI, and Community Well. The ILOC medical level of care category is composed of all members included in the ILOC - Institutional and ILOC – HCBS LTSS categories described above. For the community well medical level of care category, we developed additional eligibility indicators for Developmental Disability (DD) and Serious and Persistent Mental Illness (SPMI) populations. These flags are based on secondary aid codes and diagnosis code history of enrollees, respectively, as described below.

Beginning with the CY 2020 ratesetting, the DD Medical level of care category is now identified based on the presence of secondary aid code '14' in the IDH&W eligibility file, which is how IDH&W identifies eligible enrollees covered by the DD waiver. We have continued to use this logic to identify DD enrollees for purposes of the CY 2021 rate projections. Note that this is a change from the ratesetting approaches for calendar year's 2019 and prior, where beneficiaries were identified as DD based on diagnosis codes in the medical claims data. This new approach to identifying the DD population now aligns with IDH&W's identification of DD members. Notably, since beneficiaries covered by the DD waiver are not mandatorily enrolled under the IMPlus program, this level of care category is excluded from the IMPlus projections. A member flagged as both DD and SPMI is identified as DD.

The SPMI Medical level of care category is a condition-based category. Enrollees are identified as having an SPMI condition based on a listing of diagnosis codes. Once a member is identified as SPMI, they are flagged for the duration of their enrollment within Medicaid programs as long as they retain their Medicaid ID. IDH&W developed and produced the diagnosis codes used for identification of SPMI members. Note that for the identification of members with an SPMI condition in the MMCP and IMPlus programs, we use the combined diagnosis code list for both children with Serious Emotional Disturbance (SED) and adults with SPMI conditions. While the SED list is included for completeness, it will likely have little impact on the MMCP and IMPlus level of care assignment. Milliman has not performed any audits or review of the diagnosis codes used to identify members with this condition. These exhibits are included as Appendix D.

The remainder of the population is included in the Community Well Medical level of care category.

Costs for each level of care are trended from the base period (SFY 2019) to the projection period (CY 2021), as is described in more detail in Section 1.3.B.iii.

Additionally, area adjustments are developed to reflect program availability to eligible dual Medicare and Medicaid enrollees in a mix of counties in Idaho. Since not all counties statewide are covered by the MMCP and IMPlus programs, we applied area adjustments to the base period data to reflect area level differences in costs and provider practice patterns associated with the underlying county mix in each program. These adjustment factors were calculated by comparing the base period FFS data costs for the covered counties versus all counties statewide in the SFY 2019 FFS data. While the factors vary by sub-population, the overall composite area adjustment applied to statewide experience was approximately 0% for BCI and 0.5% for Molina in each of the MMCP and IMPlus programs.

The base year medical and LTSS claims data includes a mix of managed care (behavioral health services) and FFS (all other services). To evaluate the need for 'managed care' adjustments, we reviewed the base period FFS costs relative to actual BCI encounter data costs (for the same time period). The implied adjustments (labeled "One Time Adjustment – Managed Care") are intended to adjust the base period FFS costs to levels consistent with costs observed in the health plan encounter data. Note that due to the low credibility and material volatility in the implied Molina management adjustment factors, we set these factors to 1.0 in the Molina MMCP and IMPlus rate development. Similarly, due to low credibility of the BCI IMPlus experience, we set these management adjustment factors equal to 1.0.

See Section 1.3.B.iii for additional information regarding the data, assumptions and methodologies used to develop the projected benefit costs.

b. Material changes to the data, assumptions and methodologies since the last rate certification.

As discussed in section I.3.B.ii above, due to operational constraints, the final capitation rates are calculated as the composite of all level of care projected costs, based on an assumed membership mix. For CY 2021 rates, we have calibrated the projected level of care member mix based on current enrollment for each combination of program and MCO as of June 2020. In previous years we expected there to be material shifts in the member mix enrolled in each MCO and program and therefore used the membership mix of the overall duals' FFS population to project enrollment. However, as each program has grown there has been observable stability in the membership mix for each MCO and program that we felt justified the change in approach.

Additionally, we implemented a more refined logic, based on communication from both MCOs, to identify member status using vendor specific encounter data in conjunction with the FFS program experience. This refinement is intended to further align the calculated composite capitation rate with the realized membership mix by level of care during the contract period.

c. The amount of overpayments to providers and a description of how the state accounted for this in rate development.

There are no known amounts of overpayments made to providers. The facilities providing services, including hospitals and skilled nursing facilities are paid at an interim rate, with a final rate or settlement being paid retrospectively.

Trends [Section I.3.B.iii]:

a. *This section must include:*

(i) Data and assumptions used to develop trends:

(A) Citations for the data and sources used to develop the assumptions

Trend assumptions were applied on a per member per month (PMPM) basis. We developed a single PMPM trend rather than separate utilization and unit cost trends to increase the credibility

of the adjustments. The following tables summarize the annual trend rates assumed in the analysis.

Table 3a
Idaho Department of Health and Welfare
Medicare Medicaid Coordinated Plan (MMCP)
Estimate of PMPM Trend Rates

Member Category	Trend Rate
ILOC	
ILOC - Institutional	6.0%
ILOC - HCBS	15.0%
ILOC - Community - Well (all ages)	4.0%
Medical	0.0%

Table 3b
Idaho Department of Health and Welfare
Idaho Medicaid Plus (IMPlus)
Estimate of PMPM Trend Rates

Member Category	Trend Rate
ILOC	
ILOC - Institutional	6.0%
ILOC - HCBS	16.0%
ILOC - Community - Well (all ages)	5.0%
Medical	0.0%

We selected these annualized trend assumptions based primarily upon our review of historical Idaho Medicaid FFS data from SFY 2017 – SFY 2019 in addition to trends observed in the actual MCO program experience.

We applied the same annualized trend assumptions to in both the BCI and Molina rate projections.

In addition to our standard trend analysis, we also considered potential impact of the ongoing situation regarding the COVID-19 pandemic. There is uncertainty regarding the impact of COVID-19 on future claims costs, including whether the pandemic will increase or decrease costs in CY 2021. Note the base period data is from before the COVID-19 public health emergency. Due to the nature of these programs and the population they cover, we expected utilization to remain relatively steady compared to historical levels (versus insurance coverage for other population cohorts in other markets), as we have seen in other types of programs (for example, non-emergency transportation and dental). We typically receive MCO financial information on an annual basis, but did not receive CY 2020 financials prior to finalizing the CY 2021 rates. As a result, we did not feel there was sufficiently robust and credible information available to support an explicit COVID-19 related trend adjustment.

Based on our discussions with the State, there are no anticipated changes to the program unit cost or utilization levels that would necessitate a change in annual trend. July 2021 changes in nursing facility reimbursement by the State are not expected to immediately lead to any changes in the nursing facility reimbursement by the MCOs.

(B) Reliance on experience

Historical program experience was the primary source used to develop our trend assumptions, as described above.

(i) Methodologies used to develop trends:

We summarized the FFS and Optum encounter data for dual eligible members by state fiscal year and member level of care, limited to program covered services only. Consistent with CY 2020 rate projections, we used four distinct trend rates to produce a set of trend assumptions. We observed similar patterns in aggregate trends across groupings of level of care. The Medical level of care experience was considered in aggregate to increase the credibility of the resulting trend assumptions. LTSS trends for each member category were set to the average annual historical trend from SFY 2018 – SFY 2019 or SFY 2017 – SFY 2019. We applied a 0% annualized Medical trend for all populations, as the historical trend summaries for all populations have been negative on average from SFY 2018 – SFY 2019 and SFY 2017 – SFY 2019. We do not expect the negative trends to persist.

(iii) Comparisons to historical trends:

Trends assumptions were set based on trends observed historically for covered members in the FFS program. In cases where historical trends have been negative, we have floored the trend assumptions at 0%.

The tables below compare the updated CY 2021 trend assumptions to our prior trend assumptions assumed in the CY 2020 rate certifications as well as to the observed average historical trends in SFY17 thru SFY19.

Table 4a
Idaho Department of Health and Welfare
Medicare Medicaid Coordinated Plan (MMCP)
Summary of PMPM Trend Rate Changes

Member Category	CY20 Trend Rate	Actual SFY17 to SFY18 FFS Trends	Actual SFY18 to SFY19 FFS Trends	CY21 Trend Rate
ILOC				
ILOC - Institutional	2.7%	1.5%	6.1%	6.0%
ILOC - HCBS	3.9%	3.0%	15.3%	15.0%
ILOC - Community - Well (all ages)	0.0%	0.4%	7.4%	4.0%
Medical	0.0%	-7.1%	-3.0%	0.0%

Table 4b
Idaho Department of Health and Welfare
Idaho Medicaid Plus (IMPlus)
Summary of PMPM Trend Rate Changes

Member Category	CY20 Trend Rate	Actual SFY17 to SFY18 FFS Trends	Actual SFY18 to SFY19 FFS Trends	CY21 Trend Rate
ILOC				
ILOC - Institutional	2.7%	1.5%	6.1%	6.0%
ILOC - HCBS	4.5%	3.7%	16.1%	16.0%
ILOC - Community - Well (all ages)	0.0%	0.7%	9.3%	5.0%
Medical	0.0%	-7.0%	-3.4%	0.0%

(iv) Outlier and negative trends:

See the discussion above around handling of negative trends observed in the historical FFS program experience.

b. *Components of trend:*

As described above, trend is developed in aggregate for utilization and cost, as a single set of PMPM trends.

c. *Variations in trend:*

Trend assumptions vary by population based on variations in historical trend only.

d. *Other material adjustments to trend:*

Not applicable.

e. *Other non-material adjustments to trend:*

Not applicable.

Adjustments due to MHPAEA [Section I.3.B.iv]:

Not applicable.

In-lieu-of services [Section I.3.B.v]:

Not applicable.

Retrospective eligibility periods [Section I.3.B.vi]:

There are no adjustments in the rate development for retrospective eligibility periods. Milliman receives all claims and eligibility information with sufficient runout to appropriately reflect all eligibility determinations. When processing the FFS data, we match eligible members with the claims included in the base period used in the rate development. While costs for populations whose Medicaid eligibility is determined retrospectively is, in some cases, materially higher on a PMPM basis, this is not expected to drive a material difference in costs for the dual eligible population. We have made no adjustments to our rate projections, accordingly.

Changes to covered benefits or services [Section I.3.B.vii]:

a. *More or fewer state plan benefits covered by Medicaid managed care.*

See Section I.2.B.iii.(d).

b. *Any recoveries of overpayments made to providers by health plans in accordance with 42 CFR §438.608(d).*

See Section I.3.B.ii.(c).

c. *Requirements related to payments from health plans to any providers or class of providers.*

See Section I.4.D.

d. *Requirements or conditions of any applicable waivers.*

We are not aware of any new requirements that would be included as covered benefits under the managed care entity.

e. *Requirements of conditions of any litigation to which the state is subjected.*

We are not aware of any requirements or conditions of any litigation to which the state is subjected.

Impact of changes to covered benefits or services [Section I.3.B.viii]:

See section I.2.B.(iii).(d).

SPECIAL CONTRACT PROVISIONS RELATED TO PAYMENT [SECTION I.4]

Incentive Arrangements [Section I.4.A]

Rate Development Standards [Section I.4.A.i]

Not applicable.

Appropriate Documentation [Section I.4.A.ii]

Not applicable.

Withhold Arrangements [Section I.4.B]

Rate Development Standards [Section I.4.B.i]

Not applicable.

Appropriate Documentation [Section I.4.B.ii]

Not applicable.

Risk-Sharing Mechanisms [Section I.4.C]

Rate Development Standards [Section I.4.C.i]

See section 1.4.C.ii.

Appropriate Documentation [Section I.4.C.ii]

Consistent with prior contract periods, the state pays each vendor a single composite rate per member per month for all enrolled members. The rates in the certifications are calculated as the composite rates across all levels of care, based on an assumed, projected membership mix. The original assumptions for membership mix are reflected in the MMCP and IMPlus rate certifications. Retrospectively, on an annual basis, we calculate an updated composite rate based on the actual realized membership mix. In determining the membership mix as a part of the settlement calculation, the member level of care is held static at the assigned level of care as of three months prior to the start of each contract period. We use actual eligibility and claims data, alongside the member determination logic outlined in Appendix E, to determine each member's status. Material shifts in the membership mix during the contract period due to entries into and exits from the plans will result in an update to the vendor's ultimate PMPM capitation rate. Due to the growth observed in program enrollment and the maturity of these programs over time, the mix that enrolls may differ from the originally assumed membership mix.

There will not be any type of diagnosis based risk adjustment.

In addition to the retrospective rate adjustment for membership mix, there is also a risk sharing arrangement in the form of an MLR Settlement. Retrospectively, The MLR settlement payment will include the member mix component detailed above as well as a settlement based on the actual program experience. We use the updated, mix adjusted, composite rate in the loss ratio settlement calculation. The target MLR is 88% with a 3% corridor within which no adjustments will be made to the modified composite rates. If the MLR is lower than 85%, then the managed care organization shall remit 100% of the difference in total applicable revenue to achieve a minimum 85% MLR. If the MLR is above 91%, the State of Idaho will remit to the managed care organization 100% of the difference in total applicable revenue to achieve a maximum 91% MLR. These calculations will be done separately for each combination of vendor and program.

Delivery System and Provider Payment Initiatives [Section I.4.D]

Rate Development Standards [Section I.4.D.i]

Not applicable.

Appropriate Documentation [Section I.4.D.ii]

Not applicable.

Pass-Through Payments [Section I.4.E]

Rate Development Standards [Section I.4.E.i]

Not applicable.

Appropriate Documentation [Section I.4.E.ii]

Not applicable.

PROJECTED NON-BENEFIT COSTS [SECTION I.5]

Rate Development Standards [Section I.5.A]

See Section I.5.B.

Appropriate Documentation [Section I.5.B]

Description of non-benefit cost projection [Section I.5.B.i]:

a. Description of data, assumptions and methodologies

Table 5a and Table 5b below include the non-benefit expense assumptions as a PMPM, and separately as a percent of premium, for each combination of vendor and MCO. These non-benefit expense loads account for the administrative costs associated with facilitating a managed care program, plus any additional margin.

Table 5a Idaho Department of Health and Welfare Medicare Medicaid Coordinated Plan (MMCP) Non-Benefit Expenses Assumptions				
	CY2020		CY2021	
Carrier	PMPM	% of Premium	PMPM	% of Premium
BCI	$111.79	9.3%	$170.21	11.3%
Molina	$112.44	9.4%	$127.02	12.3%

Table 5b Idaho Department of Health and Welfare Idaho Medicaid Plus (IMPlus) Non-Benefit Expenses Assumptions				
	CY2020		CY2021	
Carrier	PMPM	% of Premium	PMPM	% of Premium
BCI	$120.86	9.4%	$156.92	9.1%
Molina	$121.66	9.4%	$130.42	8.5%

The non-benefit expense load varies by level of care, so the overall non-benefit expense load varies based on the assumed population mix. Therefore, even though there were no changes to the non-benefit expense assumptions by level of care, due to the large changes in assumed membership mix the overall non-benefit expense load now varies significantly as a percentage of premium. The original administrative expense amounts were based on the percentages originally bid by BCI. These percentages now range from 14.0% for most individual level of care groupings, down to 3.5% for the Institutional ("ILOC – Institutional") level of care for LTSS. We also previously reviewed the actual historical non-benefit expense summaries from BCI to validate this assumption. These loads account for the non-benefit costs associated with facilitating a managed care program, including administrative costs, taxes and fees, and risk margin. These loads are applied to the projected claims net of quality improvements.

1% of the non-benefit expense load is attributable to risk margin.

An additional load of $110 PMPM has been added to the managed care capitation rates to reflect the quality improvement (QI) expenditure allowance. This additional amount is based on actual quality improvement expenditures reported by the MCOs historically as part of financial accounting requirements. The QI load was proportionally allocated to each level of care accordingly. The QI load is consistent with the PMPM assumed in the CY 2020 certification. We relied on financial summaries provided by both vendors for purposes of setting the quality improvement assumptions. In discussions with BCI, it is our understanding that the methodology used to create their non-benefit and quality improvement summaries is the same methodology used to populate non-benefit expense for both the Medicare and Medicaid MLR reporting schedules. Discussions with both the managed care entities and the State supported assumption setting. Our main focus revolved around validating the values in the MCO financial statements and confirming that the itemized QI activities were in line with the general program goals. Note that in the MLR formula used for the retrospective settlement calculations, the actual quality improvement activities are treated like benefit expenditures, consistent with the approach to calculating federal MLRs.

b. Material changes to the data, assumptions and methodologies since the last rate certification.

Not applicable.

c. Other material adjustments

Not applicable.

Categories of non-benefit costs [Section I.5.B.ii]:

See Section I.5.B.i.

Historical non-benefit cost data [Section I.5.B.iii]:

The non-benefit expense components associated with quality improvement and taxes and fees are reviewed annually as part of the retrospective MLR settlement review. In addition, BCI provides a copy of the Supplemental Health Care Exhibit (SHCE) from their financial statement, which itemizes general administrative costs associated with these programs. The actual non-benefit expenses have varied materially since inception of the program(s). We expect that beginning with the

CY 2020 and CY 2021 contract periods, the non-benefit costs will begin to stabilize as the enrollment in these programs begins to stabilize.

Health Insurance Providers Fee [Section I.5.B.iv]:

Not applicable. The Health Insurance Providers Fee (HIPF) was repealed effective January 1, 2021.

RISK ADJUSTMENT AND ACUITY ADJUSTMENTS [SECTION I.6]

Rate Development Standards [Section I.6.A]

See Section I.6.B.

Appropriate Documentation [Section I.6.B]

Description of all prospective risk adjustment methodologies [Section I.6.B.i]:

Not applicable.

Description of all retrospective risk adjustment methodologies [Section I.6.B.ii]:

See Section I.4.C.ii.

Additional rate certification and supporting documentation requirements [Section I.6.B.iii]:

See Section I.4.C.ii.

Description of acuity adjustments [Section I.6.B.iv]:

The projections in Appendix A summarize the base period experience and associated adjustments by member level of care. The exhibit separately summarizes the experience for LTSS and medical services, consistent with the level of detail in which capitation rates are developed. The composite rates are calculated based on an assumed member mix in the contract period as detailed in section I.3.B.ii above. Membership is scaled to the June 2020 emerging enrollment for each combination of program and vendor.

While the MMCP program is voluntary, there are no adjustments made for favorable or adverse selection. Due to the structure of the contract, a retrospective payment will be made if the enrolled population mix in both the MMCP and the IMPlus programs differs from the assumed population distribution.

M3. MEDICAID MANAGED CARE RATES WITH LONG-TERM SERVICES AND SUPPORTS [SECTION II]

GENERAL INFORMATION [SECTION II.1]

Information Specific to MLTSS [Section II.1.A]

Please refer to Section I and note that all responses also apply to MLTSS, unless otherwise specified.

Rate Development Standards [Section II.1.B]

Rate cell structure [Section II.1.B.i]:

See Section II.1.C.i.

Appropriate Documentation [Section II.1.C]

MLTSS considerations [Section II.1.C.i]:

a. The structure of the capitation rates and rate cells or rating categories

Rates are set using a blended structure, with one composite calculation rate paid for all enrollees. See Section I.4.C.ii for additional details.

b. The structure of rates and the rate cells

Historical data is summarized and projected at the level of care level, with the composite rate calculated based on the assumed membership mix (during ratesetting) and actual membership mix (during retrospective review). See Section I.4.C.ii for additional details.

c. Any other payment structures, incentives, or disincentives used

There are no other incentives beyond those described above.

d. The expected effect that managing LTSS has on the utilization and unit costs of services

There are no modeled impacts. Within our projections there is no targeted membership or assumed shifting in the mix between institutionalized and non-institutionalized members, During the retrospective review, premium revenues are adjusted for the actual membership mix three months prior to the contract period. If the MCO is able to shift enrollees from an institutional setting to a non-institutional setting during the course of the contract year, the MCO would still receive a capitated rate based on the assumption that these members were institutionalized for the duration of the contract period. This contract structure further provides financial incentives for MCOs to effectively manage their population into non-institutionalized locations of care.

e. Any effect that the management of this care is expected to have within each care setting

There are no modeled impacts.

Non-benefit costs [Section II.1.C.ii]:

See section I.5.B.i.

Historical experience, Analysis, and Other Sources [Section II.1.C.iii]:

See Section I.1.B.i.

M4. NEW ADULT GROUP CAPITATION RATES [SECTION III]

Not applicable. The expansion population is not included as part of these rate certifications.

M5. DATA RELIANCE AND CAVEATS

This document and its attached exhibits, appendices and data are intended for use by the IDH&W in support of its CY 2021 MMCP and IMPlus capitation rates. This report may be shared with CMS for that purpose. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this presentation to other third parties. Similarly, third parties are instructed that they are to place no reliance upon this analysis prepared for the IDH&W by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. The terms of Milliman's contract with the IDH&W effective May 15, 2021 apply to this analysis and its use. Other parties receiving this report must rely upon their own experts in drawing conclusions about the data underlying the cost model. It is the responsibility of any insurance carrier to establish required revenue levels appropriate for their risk, management, and contractual obligations for the prospective population.

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual program experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis.

We have relied on data from numerous sources to compile this report. This report and associated analyses rely extensively on data provided by the IDH&W. These data include, among other items, eligibility, capitation payment records, and encounters for both major medical and mental health benefits. We have not audited this data, though we have compared some of the data provided to us to financial summaries provided by the IDH&W in order to assess the reasonableness of the data. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review of the data to search for data values that are of questionable validity or for relationships which are materially inconsistent. Such a review was beyond the scope of our assignment.

Models used in preparation of our analyses were applied consistent with their intended use. Where we relied on models developed by others, we have made a reasonable effort to understand the intended purpose, general operation, dependencies, and sensitivities of these models.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis presented herein.

M6. ACTUARIAL CERTIFICATION (MMCP)

I, Benjamin J. Diederich, am a consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Idaho Department of Health and Welfare (IDH&W) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for Idaho's managed care Medicare-Medicaid Coordinated plan program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the one year period of January 2021 to December 2021.

To the best of my information, knowledge and belief, for the January 2021 to December 2021 period, the capitation rates offered by the IDH&W are actuarially sound and comply with the requirements of 42 CFR § 438.4, the CMS Managed Care Rate Setting Guide and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on ACOs, MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the ACO, MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the IDH&W and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

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Benjamin J. Diederich, FSA, MAAA
Consulting Actuary

June 16, 2021

_____

Date

M7. ACTUARIAL CERTIFICATION (IMPLUS)

I, Benjamin J. Diederich, am a consulting actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been retained by the State of Idaho Department of Health and Welfare (IDH&W) and am familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions for Idaho's managed care Idaho Medicaid Plus program. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion. This certification is intended to cover the capitation rates presented herein for the one year period of January 2021 to December 2021.

To the best of my information, knowledge and belief, for the January 2021 to December 2021 period, the capitation rates offered by the IDH&W are actuarially sound and comply with the requirements of 42 CFR § 438.4, the CMS Managed Care Rate Setting Guide and Actuarial Standards of Practice (ASOP) No. 49. The capitation rates:

- have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- are appropriate for the populations to be covered and the services to be furnished under the contract.
- are adequate to meet the requirements on ACOs, MCOs, PIHPs, and PAHPs in § 438.206, 438.207, and 438.208.
- are specific to payments for each rate cell under the contract, and payments from any rate cell do not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- were developed in such a way that the ACO, MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8, of at least 85 percent for the rate year.

I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods.

This certification is intended for the IDH&W and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial projections of the type in this certification, so as to properly interpret the projection results. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted health plan's situation and experience.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

_____

Benjamin J. Diederich, FSA, MAAA
Consulting Actuary

June 16, 2021

_____

Date

Appendix A-1
CY 2021 Projection MMCP
Baseline Experience, Adjustments and Projected Rate Amounts
Blue Cross of Idaho

Baseline - LTSS SFY 2019[2]			One Time Adjustment - Management	One Time Adjustment - Benefit Change	Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM				Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Institutional	258	$5,771.95	1.150	1.000	1.060	$7,678.66	1.001	$7,684.50	$566.46	$8,250.97
ILOC - HCBS	3,102	$1,311.43	0.900	1.000	1.150	$1,673.90	0.997	$1,668.33	$128.70	$1,797.04
Community - Well 21-44	751	$56.90	0.700	1.000	1.040	$43.93	1.034	$45.43	$5.58	$51.02
Community - Well 45-64	1,005	$64.56	0.850	1.000	1.040	$60.53	1.061	$64.22	$6.34	$70.55
Community - Well 65+	986	$85.24	1.300	1.000	1.040	$122.23	1.028	$125.69	$8.37	$134.05
Composite	6,102	$942.50	0.942	1.000	1.097	$1,211.22	0.999	$1,209.98	$92.50	$1,302.48
Admin Percentage								10.9%	0.0%	10.2%
Total LTSS PMPM								$1,358.55	$92.50	$1,451.04

Baseline - Medical SFY 2019[2]			One Time Adjustment - Management	One Time Adjustment - Benefit Change	Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM				Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Medical	3,361	$206.54	0.650	1.000	1.000	$134.25	1.000	$134.24	$20.27	$154.51
DD - Medical	427	$121.23	0.700	1.000	1.000	$84.86	1.005	$85.27	$11.90	$97.17
SPMI - Medical	1,526	$185.14	0.950	1.000	1.000	$175.89	1.021	$179.58	$18.17	$197.75
Community - Well Medical	788	$75.87	0.800	1.000	1.000	$60.70	1.011	$61.37	$7.45	$68.82
Composite	6,102	$178.34	0.748	1.000	1.000	$131.71	1.008	$132.74	$17.50	$150.25
Admin Percentage								14.0%	0.0%	12.6%
Total Medical PMPM								$154.39	$17.50	$171.89
Total LTSS + Medical PMPM		$1,120.84				$1,342.93	1.000	$1,342.72	$110.00	$1,452.72
With Admin								$1,512.94		$1,622.94

Other Inputs	Years of Trend
	2.50

Notes:
1) Average Members are calculated based on the status of members enrolled in the BCI Medicare-Medicaid Coordinated Plan program in April 2020 - June 2020.
2) Baseline - LTSS and Baseline - Medical are SFY 2019 Non-MMCP / Non-IMPlus data for dual members across all counties, restricted to services covered under the program only.

Appendix A-2
CY 2021 Projection MMCP
Baseline Experience, Adjustments and Projected Rate Amounts
Molina

Baseline - LTSS SFY 2019[2]			One Time Adjustment - Management	One Time Adjustment - Benefit Change	Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM				Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Institutional	45	$5,771.95	1.000	1.000	1.060	$6,677.10	0.999	$6,671.25	$889.10	$7,560.35
ILOC - HCBS	732	$1,311.43	1.000	1.000	1.150	$1,859.89	0.989	$1,840.36	$202.01	$2,042.37
Community - Well 21-44	349	$56.90	1.000	1.000	1.040	$62.76	1.081	$67.86	$8.76	$76.63
Community - Well 45-64	586	$64.56	1.000	1.000	1.040	$71.21	1.154	$82.17	$9.94	$92.12
Community - Well 65+	727	$85.24	1.000	1.000	1.040	$94.03	1.106	$104.01	$13.13	$117.14
Composite	2,439	$549.65	1.000	1.000	1.073	$736.02	1.001	$736.40	$84.67	$821.06
Admin Percentage								11.9%	0.0%	10.8%
Total LTSS PMPM								$835.87	$84.67	$920.54

Baseline - Medical SFY 2019[2]			One Time Adjustment - Management	One Time Adjustment - Benefit Change	Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM				Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Medical	777	$206.54	1.000	1.000	1.000	$206.54	1.021	$210.95	$31.81	$242.76
DD - Medical	127	$121.23	1.000	1.000	1.000	$121.23	1.011	$122.55	$18.67	$141.22
SPMI - Medical	996	$185.14	1.000	1.000	1.000	$185.14	1.036	$191.84	$28.52	$220.36
Community - Well Medical	540	$75.87	1.000	1.000	1.000	$75.87	1.012	$76.79	$11.69	$88.48
Composite	2,439	$164.46	1.000	1.000	1.000	$164.46	1.027	$168.87	$25.33	$194.20
Admin Percentage								14.0%	0.0%	12.4%
Total Medical PMPM								$196.41	$25.33	$221.74
Total LTSS + Medical PMPM		$714.11				$900.49	1.005	$905.27	$110.00	$1,015.27
With Admin								$1,032.28		$1,142.28
					Years of Trend					
Other Inputs					2.50					

Notes:
1) Average Members are calculated based on the status of members enrolled in the Molina Medicare-Medicaid Coordinated Plan program in April 2020 - June 2020.
2) Baseline - LTSS and Baseline - Medical are SFY 2019 Non-MMCP / Non-IMPlus data for dual members across all counties, restricted to services covered under the program only.

Appendix A-3
CY 2021 Projection Idaho Medicaid Plus
Baseline Experience, Adjustments and Projected Rate Amounts
Blue Cross of Idaho

Baseline - LTSS SFY 2019[2]			One Time Adjustment - Management	One Time Adjustment - Benefit Change	Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM				Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Institutional	826	$5,772.81	1.000	1.000	1.060	$6,678.09	1.001	$6,683.29	$502.75	$7,186.04
ILOC - HCBS	2,298	$1,364.90	1.000	1.000	1.160	$1,978.08	0.998	$1,974.95	$118.87	$2,093.82
Community - Well 21-44	1,027	$76.94	1.000	1.000	1.050	$86.92	1.047	$90.99	$6.70	$97.69
Community - Well 45-64	1,511	$72.52	1.000	1.000	1.050	$81.93	1.069	$87.55	$6.32	$93.86
Community - Well 65+	1,888	$87.25	1.000	1.000	1.050	$98.57	1.030	$101.52	$7.60	$109.12
Composite	7,551	$1,093.70	1.000	1.000	1.085	$1,385.43	1.001	$1,387.47	$95.25	$1,482.72
Admin Percentage								8.5%	0.0%	8.0%
Total LTSS PMPM								$1,516.42	$95.25	$1,611.67

Baseline - Medical SFY 2019[2,3]			One Time Adjustment - Management	One Time Adjustment - Benefit Change	Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM				Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Medical	3,269	$206.47	1.000	1.000	1.000	$206.47	0.998	$206.12	$17.98	$224.10
DD - Medical	-	$0.00	1.000	1.000	1.000	$0.00	1.000	$0.00	$0.00	$0.00
SPMI - Medical	2,554	$185.14	1.000	1.000	1.000	$185.14	1.021	$189.03	$16.12	$205.15
Community - Well Medical	1,728	$75.87	1.000	1.000	1.000	$75.87	1.011	$76.71	$6.61	$83.32
Composite	7,551	$169.36	1.000	1.000	1.000	$169.36	1.008	$170.72	$14.75	$185.47
Admin Percentage								14.1%	0.0%	13.1%
Total Medical PMPM								$198.68	$14.75	$213.43
Total LTSS + Medical PMPM		$1,263.06				$1,554.80	1.002	$1,558.18	$110.00	$1,668.18
With Admin								$1,715.10		$1,825.10
					Years of Trend					
Other Inputs					2.50					

Notes:
1) Average Members are calculated based on the status of members enrolled in the BCI Idaho Medicaid Plus program in April 2020 - June 2020.
2) Baseline - LTSS and Baseline - Medical are SFY 2019 Non-MMCP / Non-IMPlus data for dual members across all counties, restricted to services covered under the program only.

Appendix A-4
CY 2021 Projection Idaho Medicaid Plus
Baseline Experience, Adjustments and Projected Rate Amounts
Molina

Baseline - LTSS SFY 2019[2]			One Time Adjustment - Management	One Time Adjustment - Benefit Change	Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM				Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Institutional	701	$5,772.81	1.000	1.000	1.060	$6,678.09	0.999	$6,672.28	$545.53	$7,217.82
ILOC - HCBS	1,283	$1,364.90	1.000	1.000	1.160	$1,978.08	0.990	$1,959.27	$128.98	$2,088.25
Community - Well 21-44	1,025	$76.94	1.000	1.000	1.050	$86.92	1.108	$96.35	$7.27	$103.62
Community - Well 45-64	1,366	$72.52	1.000	1.000	1.050	$81.93	1.173	$96.12	$6.85	$102.98
Community - Well 65+	1,753	$87.25	1.000	1.000	1.050	$98.57	1.111	$109.52	$8.25	$117.77
Composite	6,128	$999.64	1.000	1.000	1.074	$1,238.49	1.003	$1,241.77	$94.47	$1,336.23
Admin Percentage								7.6%	0.0%	7.1%
Total LTSS PMPM								$1,344.58	$94.47	$1,439.05

Baseline - Medical SFY 2019[2,3]			One Time Adjustment - Management	One Time Adjustment - Benefit Change	Annual Trend	Projected PMPM			Quality Improvement	
Category	Avg Mbrs[1]	PMPM				Raw Projection	Area Factor	County Adjusted PMPM	Improvement PMPM	Final PMPM
ILOC - Medical	2,087	$206.47	1.000	1.000	1.000	$206.47	1.018	$210.14	$19.51	$229.66
DD - Medical	-	$0.00	1.000	1.000	1.000	$0.00	1.000	$0.00	$0.00	$0.00
SPMI - Medical	2,469	$185.14	1.000	1.000	1.000	$185.14	1.036	$191.84	$17.50	$209.33
Community - Well Medical	1,572	$75.87	1.000	1.000	1.000	$75.87	1.012	$76.79	$7.17	$83.96
Composite	6,128	$164.37	1.000	1.000	1.000	$164.37	1.025	$168.55	$15.53	$184.09
Admin Percentage								14.1%	0.0%	13.0%
Total Medical PMPM								$196.17	$15.53	$211.70
Total LTSS + Medical PMPM		$1,164.02				$1,402.87	1.005	$1,410.32	$110.00	$1,520.32
With Admin								$1,540.74		$1,650.74

Other Inputs	Years of Trend
	2.50

Notes:
1) Average Members are calculated based on the status of members enrolled in the Molina Idaho Medicaid Plus program in April 2020 - June 2020.
2) Baseline - LTSS and Baseline - Medical are SFY 2019 Non-MMCP / Non-IMPlus data for dual members across all counties, restricted to services covered under the program only.

Appendix B
CY 2021 Summary
Medicare Medicaid Coordinated Plan (MMCP) and Idaho Medicaid Plus (IMPlus)
Covered Counties
Blue Cross of Idaho and Molina

	MMCP		IMPlus	
Counties (1)	**CY2021 Covered BCI**	**CY2021 Covered Molina**	**CY2021 Covered BCI (2)**	**CY2021 Covered Molina (2)**
Ada	X	X	X	X
Adams	X		X	
Bannock	X	X	X	X
Bear Lake				
Benewah	X		X	
Bingham	X	X	X	X
Blaine				
Boise	X	X	X	X
Bonner	X	X	X	X
Bonneville	X	X	X	X
Boundary	X	X	X	X
Butte				
Camas				
Canyon	X	X	X	X
Caribou				
Cassia	X	X	X	X
Clark	X		X	
Clearwater				
Custer				
Elmore	X	X	X	X
Franklin				
Fremont	X	X	X	X
Gem	X	X	X	X
Gooding	X		X	
Idaho				
Jefferson	X	X	X	X
Jerome	X		X	
Kootenai	X	X	X	X
Latah	X		X	
Lemhi				
Lewis				
Lincoln				
Madison	X	X	X	X
Minidoka	X	X	X	X
Nez Perce	X	X	X	X
Oneida				
Owyhee	X	X	X	X
Payette	X	X	X	X
Power	X	X	X	X
Shoshone	X		X	
Teton				
Twin Falls	X	X	X	X
Valley	X		X	
Washington	X		X	
Total Covered	30	21	30	21

Notes:
(1) Grayed out counties are not covered under either the MMCP or IMPlus programs.
(2) Counties covered as of 4/1/2020.

Milliman

Appendix C - 1
HCPCS Associated with Milliman Grouper Line Used to Identify excluded Hearing Exam claims

92521	92572	0211T
92522	92575	0212T
92523	92576	S0618
92524	92577	S9152
92550	92579	V5008
92551	92582	V5010
92552	92583	V5299
92553	92584	V5362
92555	92585	V5363
92556	92586	V5364
92557	92587	
92558	92588	
92559	92590	
92560	92591	
92561	92592	
92562	92593	
92563	92594	
92564	92595	
92565	92596	
92567	92597	
92568	0208T	
92570	0209T	
92571	0210T	

Appendix C - 2
HCPCS Associated with Milliman Grouper Line
Used to Identify excluded Home Health claims

99500	1BHMV	2BFMV	3AHNV	3CHMV	4CHMV
99501	1BHMW	2BFMW	3AHNW	3CHMW	4CHMW
99502	1BHMX	2BFMX	3AHNX	3CHMX	4CHMX
99503	1BHN1	2BGK1	3AHP1	3CHN1	5AFK1
99504	1BHN2	2BGK2	3AHP2	3CHN2	5AFK2
99505	1BHN3	2BGK3	3AHP3	3CHN3	5AFK3
99506	1BHN4	2BGK4	3AHP4	3CHN4	5AFK4
99507	1BHN5	2BGK5	3AHP5	3CHN5	5AFK5
99509	1BHN6	2BGK6	3AHP6	3CHN6	5AFK6
99510	1BHNS	2BGKS	3AHPS	3CHNS	5AFKS
99511	1BHNT	2BGKT	3AHPT	3CHNT	5AFKT
99512	1BHNU	2BGKU	3AHPU	3CHNU	5AFKU
99600	1BHNV	2BGKV	3AHPV	3CHNV	5AFKV
99601	1BHNW	2BGKW	3AHPW	3CHNW	5AFKW
99602	1BHNX	2BGKX	3AHPX	3CHNX	5AFKX
1AFK1	1BHP1	2BGL1	3BFK1	3CHP1	5AGK1
1AFK2	1BHP2	2BGL2	3BFK2	3CHP2	5AGK2
1AFK3	1BHP3	2BGL3	3BFK3	3CHP3	5AGK3
1AFK4	1BHP4	2BGL4	3BFK4	3CHP4	5AGK4
1AFK5	1BHP5	2BGL5	3BFK5	3CHP5	5AGK5
1AFK6	1BHP6	2BGL6	3BFK6	3CHP6	5AGK6
1AFKS	1BHPS	2BGLS	3BFKS	3CHPS	5AGKS
1AFKT	1BHPT	2BGLT	3BFKT	3CHPT	5AGKT
1AFKU	1BHPU	2BGLU	3BFKU	3CHPU	5AGKU
1AFKV	1BHPV	2BGLV	3BFKV	3CHPV	5AGKV
1AFKW	1BHPW	2BGLW	3BFKW	3CHPW	5AGKW
1AFKX	1BHPX	2BGLX	3BFKX	3CHPX	5AGKX
1AFL1	1CFK1	2BGM1	3BFL1	4AFK1	5AHK1
1AFL2	1CFK2	2BGM2	3BFL2	4AFK2	5AHK2
1AFL3	1CFK3	2BGM3	3BFL3	4AFK3	5AHK3
1AFL4	1CFK4	2BGM4	3BFL4	4AFK4	5AHK4
1AFL5	1CFK5	2BGM5	3BFL5	4AFK5	5AHK5
1AFL6	1CFK6	2BGM6	3BFL6	4AFK6	5AHK6
1AFLS	1CFKS	2BGMS	3BFLS	4AFKS	5AHKS
1AFLT	1CFKT	2BGMT	3BFLT	4AFKT	5AHKT
1AFLU	1CFKU	2BGMU	3BFLU	4AFKU	5AHKU
1AFLV	1CFKV	2BGMV	3BFLV	4AFKV	5AHKV
1AFLW	1CFKW	2BGMW	3BFLW	4AFKW	5AHKW
1AFLX	1CFKX	2BGMX	3BFLX	4AFKX	5AHKX
1AFM1	1CFL1	2BHK1	3BFM1	4AFL1	5BFK1
1AFM2	1CFL2	2BHK2	3BFM2	4AFL2	5BFK2
1AFM3	1CFL3	2BHK3	3BFM3	4AFL3	5BFK3
1AFM4	1CFL4	2BHK4	3BFM4	4AFL4	5BFK4
1AFM5	1CFL5	2BHK5	3BFM5	4AFL5	5BFK5
1AFM6	1CFL6	2BHK6	3BFM6	4AFL6	5BFK6
1AFMS	1CFLS	2BHKS	3BFMS	4AFLS	5BFKS
1AFMT	1CFLT	2BHKT	3BFMT	4AFLT	5BFKT
1AFMU	1CFLU	2BHKU	3BFMU	4AFLU	5BFKU
1AFMV	1CFLV	2BHKV	3BFMV	4AFLV	5BFKV
1AFMW	1CFLW	2BHKW	3BFMW	4AFLW	5BFKW
1AFMX	1CFLX	2BHKX	3BFMX	4AFLX	5BFKX
1AFN1	1CFM1	2BHL1	3BFN1	4AFM1	5BGK1
1AFN2	1CFM2	2BHL2	3BFN2	4AFM2	5BGK2
1AFN3	1CFM3	2BHL3	3BFN3	4AFM3	5BGK3
1AFN4	1CFM4	2BHL4	3BFN4	4AFM4	5BGK4

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1AFN5	1CFM5	2BHL5	3BFN5	4AFM5	5BGK5
1AFN6	1CFM6	2BHL6	3BFN6	4AFM6	5BGK6
1AFNS	1CFMS	2BHLS	3BFNS	4AFMS	5BGKS
1AFNT	1CFMT	2BHLT	3BFNT	4AFMT	5BGKT
1AFNU	1CFMU	2BHLU	3BFNU	4AFMU	5BGKU
1AFNV	1CFMV	2BHLV	3BFNV	4AFMV	5BGKV
1AFNW	1CFMW	2BHLW	3BFNW	4AFMW	5BGKW
1AFNX	1CFMX	2BHLX	3BFNX	4AFMX	5BGKX
1AFP1	1CFN1	2BHM1	3BFP1	4AGK1	5BHK1
1AFP2	1CFN2	2BHM2	3BFP2	4AGK2	5BHK2
1AFP3	1CFN3	2BHM3	3BFP3	4AGK3	5BHK3
1AFP4	1CFN4	2BHM4	3BFP4	4AGK4	5BHK4
1AFP5	1CFN5	2BHM5	3BFP5	4AGK5	5BHK5
1AFP6	1CFN6	2BHM6	3BFP6	4AGK6	5BHK6
1AFPS	1CFNS	2BHMS	3BFPS	4AGKS	5BHKS
1AFPT	1CFNT	2BHMT	3BFPT	4AGKT	5BHKT
1AFPU	1CFNU	2BHMU	3BFPU	4AGKU	5BHKU
1AFPV	1CFNV	2BHMV	3BFPV	4AGKV	5BHKV
1AFPW	1CFNW	2BHMW	3BFPW	4AGKW	5BHKW
1AFPX	1CFNX	2BHMX	3BFPX	4AGKX	5BHKX
1AGK1	1CFP1	2CFK1	3BGK1	4AGL1	5CFK1
1AGK2	1CFP2	2CFK2	3BGK2	4AGL2	5CFK2
1AGK3	1CFP3	2CFK3	3BGK3	4AGL3	5CFK3
1AGK4	1CFP4	2CFK4	3BGK4	4AGL4	5CFK4
1AGK5	1CFP5	2CFK5	3BGK5	4AGL5	5CFK5
1AGK6	1CFP6	2CFK6	3BGK6	4AGL6	5CFK6
1AGKS	1CFPS	2CFKS	3BGKS	4AGLS	5CFKS
1AGKT	1CFPT	2CFKT	3BGKT	4AGLT	5CFKT
1AGKU	1CFPU	2CFKU	3BGKU	4AGLU	5CFKU
1AGKV	1CFPV	2CFKV	3BGKV	4AGLV	5CFKV
1AGKW	1CFPW	2CFKW	3BGKW	4AGLW	5CFKW
1AGKX	1CFPX	2CFKX	3BGKX	4AGLX	5CFKX
1AGL1	1CGK1	2CFL1	3BGL1	4AGM1	5CGK1
1AGL2	1CGK2	2CFL2	3BGL2	4AGM2	5CGK2
1AGL3	1CGK3	2CFL3	3BGL3	4AGM3	5CGK3
1AGL4	1CGK4	2CFL4	3BGL4	4AGM4	5CGK4
1AGL5	1CGK5	2CFL5	3BGL5	4AGM5	5CGK5
1AGL6	1CGK6	2CFL6	3BGL6	4AGM6	5CGK6
1AGLS	1CGKS	2CFLS	3BGLS	4AGMS	5CGKS
1AGLT	1CGKT	2CFLT	3BGLT	4AGMT	5CGKT
1AGLU	1CGKU	2CFLU	3BGLU	4AGMU	5CGKU
1AGLV	1CGKV	2CFLV	3BGLV	4AGMV	5CGKV
1AGLW	1CGKW	2CFLW	3BGLW	4AGMW	5CGKW
1AGLX	1CGKX	2CFLX	3BGLX	4AGMX	5CGKX
1AGM1	1CGL1	2CFM1	3BGM1	4AHK1	5CHK1
1AGM2	1CGL2	2CFM2	3BGM2	4AHK2	5CHK2
1AGM3	1CGL3	2CFM3	3BGM3	4AHK3	5CHK3
1AGM4	1CGL4	2CFM4	3BGM4	4AHK4	5CHK4
1AGM5	1CGL5	2CFM5	3BGM5	4AHK5	5CHK5
1AGM6	1CGL6	2CFM6	3BGM6	4AHK6	5CHK6
1AGMS	1CGLS	2CFMS	3BGMS	4AHKS	5CHKS
1AGMT	1CGLT	2CFMT	3BGMT	4AHKT	5CHKT
1AGMU	1CGLU	2CFMU	3BGMU	4AHKU	5CHKU
1AGMV	1CGLV	2CFMV	3BGMV	4AHKV	5CHKV
1AGMW	1CGLW	2CFMW	3BGMW	4AHKW	5CHKW

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1AGMX	1CGLX	2CFMX	3BGMX	4AHKX	5CHKX
1AGN1	1CGM1	2CGK1	3BGN1	4AHL1	G0068
1AGN2	1CGM2	2CGK2	3BGN2	4AHL2	G0069
1AGN3	1CGM3	2CGK3	3BGN3	4AHL3	G0070
1AGN4	1CGM4	2CGK4	3BGN4	4AHL4	G0076
1AGN5	1CGM5	2CGK5	3BGN5	4AHL5	G0077
1AGN6	1CGM6	2CGK6	3BGN6	4AHL6	G0078
1AGNS	1CGMS	2CGKS	3BGNS	4AHLS	G0079
1AGNT	1CGMT	2CGKT	3BGNT	4AHLT	G0080
1AGNU	1CGMU	2CGKU	3BGNU	4AHLU	G0081
1AGNV	1CGMV	2CGKV	3BGNV	4AHLV	G0082
1AGNW	1CGMW	2CGKW	3BGNW	4AHLW	G0083
1AGNX	1CGMX	2CGKX	3BGNX	4AHLX	G0084
1AGP1	1CGN1	2CGL1	3BGP1	4AHM1	G0085
1AGP2	1CGN2	2CGL2	3BGP2	4AHM2	G0086
1AGP3	1CGN3	2CGL3	3BGP3	4AHM3	G0087
1AGP4	1CGN4	2CGL4	3BGP4	4AHM4	G0151
1AGP5	1CGN5	2CGL5	3BGP5	4AHM5	G0152
1AGP6	1CGN6	2CGL6	3BGP6	4AHM6	G0153
1AGPS	1CGNS	2CGLS	3BGPS	4AHMS	G0155
1AGPT	1CGNT	2CGLT	3BGPT	4AHMT	G0156
1AGPU	1CGNU	2CGLU	3BGPU	4AHMU	G0157
1AGPV	1CGNV	2CGLV	3BGPV	4AHMV	G0158
1AGPW	1CGNW	2CGLW	3BGPW	4AHMW	G0159
1AGPX	1CGNX	2CGLX	3BGPX	4AHMX	G0160
1AHK1	1CGP1	2CGM1	3BHK1	4BFK1	G0161
1AHK2	1CGP2	2CGM2	3BHK2	4BFK2	G0162
1AHK3	1CGP3	2CGM3	3BHK3	4BFK3	G0299
1AHK4	1CGP4	2CGM4	3BHK4	4BFK4	G0300
1AHK5	1CGP5	2CGM5	3BHK5	4BFK5	G0490
1AHK6	1CGP6	2CGM6	3BHK6	4BFK6	G0493
1AHKS	1CGPS	2CGMS	3BHKS	4BFKS	G0494
1AHKT	1CGPT	2CGMT	3BHKT	4BFKT	G0495
1AHKU	1CGPU	2CGMU	3BHKU	4BFKU	G0496
1AHKV	1CGPV	2CGMV	3BHKV	4BFKV	G9473
1AHKW	1CGPW	2CGMW	3BHKW	4BFKW	G9474
1AHKX	1CGPX	2CGMX	3BHKX	4BFKX	G9475
1AHL1	1CHK1	2CHK1	3BHL1	4BFL1	G9476
1AHL2	1CHK2	2CHK2	3BHL2	4BFL2	G9477
1AHL3	1CHK3	2CHK3	3BHL3	4BFL3	G9478
1AHL4	1CHK4	2CHK4	3BHL4	4BFL4	G9479
1AHL5	1CHK5	2CHK5	3BHL5	4BFL5	G9490
1AHL6	1CHK6	2CHK6	3BHL6	4BFL6	Q2052
1AHLS	1CHKS	2CHKS	3BHLS	4BFLS	Q5001
1AHLT	1CHKT	2CHKT	3BHLT	4BFLT	Q5003
1AHLU	1CHKU	2CHKU	3BHLU	4BFLU	Q5004
1AHLV	1CHKV	2CHKV	3BHLV	4BFLV	Q5005
1AHLW	1CHKW	2CHKW	3BHLW	4BFLW	Q5006
1AHLX	1CHKX	2CHKX	3BHLX	4BFLX	Q5007
1AHM1	1CHL1	2CHL1	3BHM1	4BFM1	Q5008
1AHM2	1CHL2	2CHL2	3BHM2	4BFM2	Q5009
1AHM3	1CHL3	2CHL3	3BHM3	4BFM3	Q5010
1AHM4	1CHL4	2CHL4	3BHM4	4BFM4	S0270
1AHM5	1CHL5	2CHL5	3BHM5	4BFM5	S0271
1AHM6	1CHL6	2CHL6	3BHM6	4BFM6	S0272

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1AHMS	1CHLS	2CHLS	3BHMS	4BFMS	S5035
1AHMT	1CHLT	2CHLT	3BHMT	4BFMT	S5036
1AHMU	1CHLU	2CHLU	3BHMU	4BFMU	S5100
1AHMV	1CHLV	2CHLV	3BHMV	4BFMV	S5101
1AHMW	1CHLW	2CHLW	3BHMW	4BFMW	S5102
1AHMX	1CHLX	2CHLX	3BHMX	4BFMX	S5105
1AHN1	1CHM1	2CHM1	3BHN1	4BGK1	S5108
1AHN2	1CHM2	2CHM2	3BHN2	4BGK2	S5109
1AHN3	1CHM3	2CHM3	3BHN3	4BGK3	S5110
1AHN4	1CHM4	2CHM4	3BHN4	4BGK4	S5111
1AHN5	1CHM5	2CHM5	3BHN5	4BGK5	S5115
1AHN6	1CHM6	2CHM6	3BHN6	4BGK6	S5116
1AHNS	1CHMS	2CHMS	3BHNS	4BGKS	S5120
1AHNT	1CHMT	2CHMT	3BHNT	4BGKT	S5121
1AHNU	1CHMU	2CHMU	3BHNU	4BGKU	S5125
1AHNV	1CHMV	2CHMV	3BHNV	4BGKV	S5126
1AHNW	1CHMW	2CHMW	3BHNW	4BGKW	S5130
1AHNX	1CHMX	2CHMX	3BHNX	4BGKX	S5131
1AHP1	1CHN1	3AFK1	3BHP1	4BGL1	S5135
1AHP2	1CHN2	3AFK2	3BHP2	4BGL2	S5136
1AHP3	1CHN3	3AFK3	3BHP3	4BGL3	S5140
1AHP4	1CHN4	3AFK4	3BHP4	4BGL4	S5141
1AHP5	1CHN5	3AFK5	3BHP5	4BGL5	S5145
1AHP6	1CHN6	3AFK6	3BHP6	4BGL6	S5146
1AHPS	1CHNS	3AFKS	3BHPS	4BGLS	S5150
1AHPT	1CHNT	3AFKT	3BHPT	4BGLT	S5151
1AHPU	1CHNU	3AFKU	3BHPU	4BGLU	S5160
1AHPV	1CHNV	3AFKV	3BHPV	4BGLV	S5161
1AHPW	1CHNW	3AFKW	3BHPW	4BGLW	S5162
1AHPX	1CHNX	3AFKX	3BHPX	4BGLX	S5165
1BFK1	1CHP1	3AFL1	3CFK1	4BGM1	S5170
1BFK2	1CHP2	3AFL2	3CFK2	4BGM2	S5175
1BFK3	1CHP3	3AFL3	3CFK3	4BGM3	S5180
1BFK4	1CHP4	3AFL4	3CFK4	4BGM4	S5181
1BFK5	1CHP5	3AFL5	3CFK5	4BGM5	S5497
1BFK6	1CHP6	3AFL6	3CFK6	4BGM6	S5498
1BFKS	1CHPS	3AFLS	3CFKS	4BGMS	S5501
1BFKT	1CHPT	3AFLT	3CFKT	4BGMT	S5502
1BFKU	1CHPU	3AFLU	3CFKU	4BGMU	S5517
1BFKV	1CHPV	3AFLV	3CFKV	4BGMV	S5518
1BFKW	1CHPW	3AFLW	3CFKW	4BGMW	S5520
1BFKX	1CHPX	3AFLX	3CFKX	4BGMX	S5521
1BFL1	2AFK1	3AFM1	3CFL1	4BHK1	S5522
1BFL2	2AFK2	3AFM2	3CFL2	4BHK2	S5523
1BFL3	2AFK3	3AFM3	3CFL3	4BHK3	S9097
1BFL4	2AFK4	3AFM4	3CFL4	4BHK4	S9098
1BFL5	2AFK5	3AFM5	3CFL5	4BHK5	S9110
1BFL6	2AFK6	3AFM6	3CFL6	4BHK6	S9122
1BFLS	2AFKS	3AFMS	3CFLS	4BHKS	S9123
1BFLT	2AFKT	3AFMT	3CFLT	4BHKT	S9124
1BFLU	2AFKU	3AFMU	3CFLU	4BHKU	S9125
1BFLV	2AFKV	3AFMV	3CFLV	4BHKV	S9126
1BFLW	2AFKW	3AFMW	3CFLW	4BHKW	S9127
1BFLX	2AFKX	3AFMX	3CFLX	4BHKX	S9128
1BFM1	2AFL1	3AFN1	3CFM1	4BHL1	S9129

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1BFM2	2AFL2	3AFN2	3CFM2	4BHL2	S9131
1BFM3	2AFL3	3AFN3	3CFM3	4BHL3	S9208
1BFM4	2AFL4	3AFN4	3CFM4	4BHL4	S9209
1BFM5	2AFL5	3AFN5	3CFM5	4BHL5	S9211
1BFM6	2AFL6	3AFN6	3CFM6	4BHL6	S9212
1BFMS	2AFLS	3AFNS	3CFMS	4BHLS	S9213
1BFMT	2AFLT	3AFNT	3CFMT	4BHLT	S9214
1BFMU	2AFLU	3AFNU	3CFMU	4BHLU	S9325
1BFMV	2AFLV	3AFNV	3CFMV	4BHLV	S9326
1BFMW	2AFLW	3AFNW	3CFMW	4BHLW	S9327
1BFMX	2AFLX	3AFNX	3CFMX	4BHLX	S9328
1BFN1	2AFM1	3AFP1	3CFN1	4BHM1	S9329
1BFN2	2AFM2	3AFP2	3CFN2	4BHM2	S9330
1BFN3	2AFM3	3AFP3	3CFN3	4BHM3	S9331
1BFN4	2AFM4	3AFP4	3CFN4	4BHM4	S9336
1BFN5	2AFM5	3AFP5	3CFN5	4BHM5	S9338
1BFN6	2AFM6	3AFP6	3CFN6	4BHM6	S9340
1BFNS	2AFMS	3AFPS	3CFNS	4BHMS	S9341
1BFNT	2AFMT	3AFPT	3CFNT	4BHMT	S9342
1BFNU	2AFMU	3AFPU	3CFNU	4BHMU	S9343
1BFNV	2AFMV	3AFPV	3CFNV	4BHMV	S9345
1BFNW	2AFMW	3AFPW	3CFNW	4BHMW	S9346
1BFNX	2AFMX	3AFPX	3CFNX	4BHMX	S9347
1BFP1	2AGK1	3AGK1	3CFP1	4CFK1	S9348
1BFP2	2AGK2	3AGK2	3CFP2	4CFK2	S9349
1BFP3	2AGK3	3AGK3	3CFP3	4CFK3	S9351
1BFP4	2AGK4	3AGK4	3CFP4	4CFK4	S9353
1BFP5	2AGK5	3AGK5	3CFP5	4CFK5	S9355
1BFP6	2AGK6	3AGK6	3CFP6	4CFK6	S9357
1BFPS	2AGKS	3AGKS	3CFPS	4CFKS	S9359
1BFPT	2AGKT	3AGKT	3CFPT	4CFKT	S9361
1BFPU	2AGKU	3AGKU	3CFPU	4CFKU	S9363
1BFPV	2AGKV	3AGKV	3CFPV	4CFKV	S9364
1BFPW	2AGKW	3AGKW	3CFPW	4CFKW	S9365
1BFPX	2AGKX	3AGKX	3CFPX	4CFKX	S9366
1BGK1	2AGL1	3AGL1	3CGK1	4CFL1	S9367
1BGK2	2AGL2	3AGL2	3CGK2	4CFL2	S9368
1BGK3	2AGL3	3AGL3	3CGK3	4CFL3	S9370
1BGK4	2AGL4	3AGL4	3CGK4	4CFL4	S9372
1BGK5	2AGL5	3AGL5	3CGK5	4CFL5	S9373
1BGK6	2AGL6	3AGL6	3CGK6	4CFL6	S9374
1BGKS	2AGLS	3AGLS	3CGKS	4CFLS	S9375
1BGKT	2AGLT	3AGLT	3CGKT	4CFLT	S9376
1BGKU	2AGLU	3AGLU	3CGKU	4CFLU	S9377
1BGKV	2AGLV	3AGLV	3CGKV	4CFLV	S9379
1BGKW	2AGLW	3AGLW	3CGKW	4CFLW	S9381
1BGKX	2AGLX	3AGLX	3CGKX	4CFLX	S9490
1BGL1	2AGM1	3AGM1	3CGL1	4CFM1	S9494
1BGL2	2AGM2	3AGM2	3CGL2	4CFM2	S9497
1BGL3	2AGM3	3AGM3	3CGL3	4CFM3	S9500
1BGL4	2AGM4	3AGM4	3CGL4	4CFM4	S9501
1BGL5	2AGM5	3AGM5	3CGL5	4CFM5	S9502
1BGL6	2AGM6	3AGM6	3CGL6	4CFM6	S9503
1BGLS	2AGMS	3AGMS	3CGLS	4CFMS	S9504
1BGLT	2AGMT	3AGMT	3CGLT	4CFMT	S9537

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1BGLU	2AGMU	3AGMU	3CGLU	4CFMU	S9538
1BGLV	2AGMV	3AGMV	3CGLV	4CFMV	S9542
1BGLW	2AGMW	3AGMW	3CGLW	4CFMW	S9558
1BGLX	2AGMX	3AGMX	3CGLX	4CFMX	S9559
1BGM1	2AHK1	3AGN1	3CGM1	4CGK1	S9560
1BGM2	2AHK2	3AGN2	3CGM2	4CGK2	S9562
1BGM3	2AHK3	3AGN3	3CGM3	4CGK3	S9590
1BGM4	2AHK4	3AGN4	3CGM4	4CGK4	S9810
1BGM5	2AHK5	3AGN5	3CGM5	4CGK5	T1000
1BGM6	2AHK6	3AGN6	3CGM6	4CGK6	T1001
1BGMS	2AHKS	3AGNS	3CGMS	4CGKS	T1002
1BGMT	2AHKT	3AGNT	3CGMT	4CGKT	T1003
1BGMU	2AHKU	3AGNU	3CGMU	4CGKU	T1004
1BGMV	2AHKV	3AGNV	3CGMV	4CGKV	T1005
1BGMW	2AHKW	3AGNW	3CGMW	4CGKW	T1021
1BGMX	2AHKX	3AGNX	3CGMX	4CGKX	T1030
1BGN1	2AHL1	3AGP1	3CGN1	4CGL1	T1031
1BGN2	2AHL2	3AGP2	3CGN2	4CGL2	T2042
1BGN3	2AHL3	3AGP3	3CGN3	4CGL3	T2043
1BGN4	2AHL4	3AGP4	3CGN4	4CGL4	T2044
1BGN5	2AHL5	3AGP5	3CGN5	4CGL5	T2045
1BGN6	2AHL6	3AGP6	3CGN6	4CGL6	T2046
1BGNS	2AHLS	3AGPS	3CGNS	4CGLS	
1BGNT	2AHLT	3AGPT	3CGNT	4CGLT	
1BGNU	2AHLU	3AGPU	3CGNU	4CGLU	
1BGNV	2AHLV	3AGPV	3CGNV	4CGLV	
1BGNW	2AHLW	3AGPW	3CGNW	4CGLW	
1BGNX	2AHLX	3AGPX	3CGNX	4CGLX	
1BGP1	2AHM1	3AHK1	3CGP1	4CGM1	
1BGP2	2AHM2	3AHK2	3CGP2	4CGM2	
1BGP3	2AHM3	3AHK3	3CGP3	4CGM3	
1BGP4	2AHM4	3AHK4	3CGP4	4CGM4	
1BGP5	2AHM5	3AHK5	3CGP5	4CGM5	
1BGP6	2AHM6	3AHK6	3CGP6	4CGM6	
1BGPS	2AHMS	3AHKS	3CGPS	4CGMS	
1BGPT	2AHMT	3AHKT	3CGPT	4CGMT	
1BGPU	2AHMU	3AHKU	3CGPU	4CGMU	
1BGPV	2AHMV	3AHKV	3CGPV	4CGMV	
1BGPW	2AHMW	3AHKW	3CGPW	4CGMW	
1BGPX	2AHMX	3AHKX	3CGPX	4CGMX	
1BHK1	2BFK1	3AHL1	3CHK1	4CHK1	
1BHK2	2BFK2	3AHL2	3CHK2	4CHK2	
1BHK3	2BFK3	3AHL3	3CHK3	4CHK3	
1BHK4	2BFK4	3AHL4	3CHK4	4CHK4	
1BHK5	2BFK5	3AHL5	3CHK5	4CHK5	
1BHK6	2BFK6	3AHL6	3CHK6	4CHK6	
1BHKS	2BFKS	3AHLS	3CHKS	4CHKS	
1BHKT	2BFKT	3AHLT	3CHKT	4CHKT	
1BHKU	2BFKU	3AHLU	3CHKU	4CHKU	
1BHKV	2BFKV	3AHLV	3CHKV	4CHKV	
1BHKW	2BFKW	3AHLW	3CHKW	4CHKW	
1BHKX	2BFKX	3AHLX	3CHKX	4CHKX	
1BHL1	2BFL1	3AHM1	3CHL1	4CHL1	
1BHL2	2BFL2	3AHM2	3CHL2	4CHL2	
1BHL3	2BFL3	3AHM3	3CHL3	4CHL3	

Appendix C - 2
HCPCS Associated with Milliman Grouper Line
Used to Identify excluded Home Health claims

1BHL4	2BFL4	3AHM4	3CHL4	4CHL4
1BHL5	2BFL5	3AHM5	3CHL5	4CHL5
1BHL6	2BFL6	3AHM6	3CHL6	4CHL6
1BHLS	2BFLS	3AHMS	3CHLS	4CHLS
1BHLT	2BFLT	3AHMT	3CHLT	4CHLT
1BHLU	2BFLU	3AHMU	3CHLU	4CHLU
1BHLV	2BFLV	3AHMV	3CHLV	4CHLV
1BHLW	2BFLW	3AHMW	3CHLW	4CHLW
1BHLX	2BFLX	3AHMX	3CHLX	4CHLX
1BHM1	2BFM1	3AHN1	3CHM1	4CHM1
1BHM2	2BFM2	3AHN2	3CHM2	4CHM2
1BHM3	2BFM3	3AHN3	3CHM3	4CHM3
1BHM4	2BFM4	3AHN4	3CHM4	4CHM4
1BHM5	2BFM5	3AHN5	3CHM5	4CHM5
1BHM6	2BFM6	3AHN6	3CHM6	4CHM6
1BHMS	2BFMS	3AHNS	3CHMS	4CHMS
1BHMT	2BFMT	3AHNT	3CHMT	4CHMT
1BHMU	2BFMU	3AHNU	3CHMU	4CHMU

Appendix D
Diagnosis Codes Associated with SPMI flag

SPMI		Serious Emotional Disturbance (SED)				
29500	29655	29500	29613	30110	F321	F40233
29501	29656	29501	29614	30111	F322	F40240
29502	29660	29502	29615	30112	F323	F40241
29503	29661	29503	29616	30113	F324	F40242
29504	29662	29504	29620	30120	F325	F40243
29505	29663	29505	29621	30121	F3340	F40248
29510	29664	29510	29622	30122	F339	F40290
29511	29665	29511	29623	3013	F330	F40291
29512	29666	29512	29624	3014	F331	F40298
29513	2967	29513	29625	30150	F332	F408
29514	29689	29514	29626	30151	F333	F42
29515	29633	29515	29630	30159	F3341	F341
29520	29634	29520	29631	3016	F3342	F600
29521	2971	29521	29632	30189	F310	F340
29522	2989	29522	29633	3019	F3110	F6089
29523	30183	29523	29634	3071	F3189	F601
29524	F2089	29524	29635	30720	F3111	F21
29525	F201	29525	29636	30721	F3112	F603
29530	F202	29530	29640	30722	F3113	F605
29531	F200	29531	29641	3073	F312	F604
29532	F205	29532	29642	30750	F3173	F6810
29533	F203	29533	29643	30751	F3174	F6812
29534	F209	29534	29644	30752	F3130	F6813
29535	F23	29535	29645	30753	F3131	F607
29550	F250	29540	29646	30754	F3132	F609
29551	F251	29541	29650	30759	F314	F69
29552	F258	29542	29651	3076	F315	F5000
29553	F259	29543	29652	3077	F3175	F5001
29554	F3010	29544	29653	30921	F3176	F5002
29555	F309	29545	29654	30981	F3160	F958
29560	F3011	29550	29655	311	F3161	F959
29561	F3012	29551	29656	3130	F3162	F950
29562	F3013	29552	29660	3131	F3163	F951
29563	F302	29553	29661	31321	F3164	F984
29564	F303	29554	29662	31322	F3177	F509
29565	F304	29555	29663	31323	F3178	F502
29590	F310	29560	29664	31381	F3170	F983
29591	F3110	29561	29665	31382	F3171	F9821
29592	F3189	29562	29666	31383	F3172	F508
29593	F3111	29563	2967	31389	F319	F9829
29594	F3112	29564	29680	3139	F308	F980
29570	F3113	29565	29681	31400	F328	F981
29571	F312	29580	29682	31401	F3181	F930
29572	F3173	29581	29689	3141	F39	F4310
29573	F3174	29582	29690	3142	F338	F4311
29574	F3130	29583	29699	3148	F348	F4312
29600	F3131	29584	2970	3149	F349	F938
29601	F3132	29585	2971	F2089	F22	F940
29602	F314	29590	2978	F201	F28	F913
29603	F315	29591	2979	F202	F4489	F941
29604	F3175	29592	2980	F200	F29	F942
29605	F3176	29593	2981	F2081	F419	F949

Appendix D
Diagnosis Codes Associated with SPMI flag

SPMI		Serious Emotional Disturbance (SED)				
29606	F3160	29594	2982	F205	F410	F988
29610	F3161	29595	2983	F203	F411	F939
29611	F3162	29570	2984	F23	F413	F948
29612	F3163	29571	2988	F209	F418	F989
29613	F3164	29572	2989	F250	F4481	F900
29614	F3177	29573	30000	F251	F409	F909
29640	F3178	29574	30001	F258	F4001	F901
29641	F3170	29575	30002	F259	F4000	F902
29642	F3171	29600	30009	F3010	F4002	F908
29643	F3172	29601	30014	F309	F4010	
29644	F319	29602	30020	F3011	F4011	
29645	F3181	29603	30021	F3012	F40210	
29646	F332	29604	30022	F3013	F40218	
29650	F333	29605	30023	F302	F40220	
29651	F22	29606	30029	F303	F40228	
29652	F28	29610	3003	F304	F40230	
29653	F29	29611	3004	F329	F40231	
29654	F603	29612	3010	F320	F40232	

Appendix E

This appendix provides the technical details relating to the LTSS level of care groupings.

Level of Care Groupings - LTSS

As noted in the main report, we have separated dual eligible Medicaid members into three main population types: Institutional, HCBS, and Community Well. For the LTSS cost projections, the Community Well category is further subdivided to rate cells based on the member's age (21-44, 45-64, and 65+).

The logic of member categorization is hierarchical. Members are flagged as Institutional Level of Care (ILOC) - Institutional in a particular month if they have had 21 or more days of nursing facility services within that month. Members who are not flagged as institutional in a month are flagged as HCBS if they have long-term care category of service claims (outside of nursing facility). All other members are considered to be Community Well.

As a member's rate cell category is based on a member's own claims experience, we use the MMCP- and IMPlus-specific encounter data provided by the Managed Care Organizations (MCO) to assign the rate cells of the members based on the level of services needed. If the member is not participating in the MMCP or IMPlus program for the month in which we are evaluating the member's status, the fee-for-service (FFS) data, in conjunction with the encounter data from the state's mental health managed care organization (Optum), is used to assign the member status.

Fee-for-Service Participants

In the FFS data, the source Specialty code is used to identify nursing facilities and other long-term care claims.

- Institutional Level of Care – Institutional
    - Identified preliminarily based on data field(s): srcSpecialty
        - Skilled Nursing Facility
        - PCS Case Management
- Institutional Level of Care – HCBS
    - Based on data field(s): srcSpecialty
        - Emergency response system companies
        - Home Delivered Meals
        - Agency Transportation
        - Nursing Agency (PDN)
        - Assistive Technology Supplier
        - PCS/Aged & Disabled Services Agency
        - Residential Assisted Living Facility (RALF)
        - Adult Day Care
        - PCS Family Alternate Care Home
        - Intermediate Care Facility, Mental Illness - IMD/NH State
        - Medicare Defined Swing Bed Unit
        - Registered Nurse -Independent (PDN)
        - Commercial Transportation
        - Individual Transportation Provider
        - TBI (Traumatic Brain Injury)
        - PCS Family Alternate Care Home – DD Children

If a member does not qualify for the Institutional or HCBS rate cells, then they are placed in the Community Well category, and the age grouping is assigned based on eligibility for the month.

MMCP & IMPlus Participants

For members who are participating in the MMCP or IMPlus programs with Blue Cross of Idaho or Molina at the time of the rate cell determination, we rely on an analogous mapping to identify nursing facilities and other long-term care claims in the encounter data.

- Institutional Level of Care – Institutional
    - Identified preliminarily based on data field(s): srcPOS and BillType
- Institutional Level of Care – HCBS
    - Based on data field(s): srcSpecialty
        - Clinic/Center - Adult Day Care
        - Homemaker Services
        - Community Based Rehabilitative
        - Home Delivered Meals
        - DME Supplier
        - Personal Emergency Response
        - Technician - Attendant Care
        - Residential Assisted Living
        - Certified Family Home
        - Residential Habilitation